“I CANNOT SLEEP”: PATIENT EXPERIENCES AND THE MEANINGS OF MADNESS IN BETHEL HOSPITAL, 1713-1815

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Abstract

This thesis examines the history of the Bethel Hospital for 'lunatics' in Norwich, the second public institution for the mad in Britain, from its 1713 founding until 1815. Combining a patient-centred approach with methods of discourse analysis, it focuses particularly on recovering the identities and experiences of the hospital's inmates. It seeks first and foremost to understand the lives of these individuals on their own terms as persons, rather than the labels that the institution and their communities at large often reduced them to. To do so, it pieces together a variety of contemporary source material, including newspapers, legal records, and coroner's inquests, in addition to the extant records kept by the hospital administration itself. First, I examine the ways in which English popular and medical sectors of society conceptualized madness, thereby finding commonalities in the sorts of people that were deemed mad and confined at Bethel Hospital in relation to gendered and socioeconomic factors. Next, considerations of Bethel's architecture and geography are used to illustrate aspects of patients' experiences of confinement, treatment, and restraint, as well as the various ways they were able to resist or, alternately, work within these impositions. Finally, I reconstruct individual patients' narratives as a means to better understand their holistic experiences living under the label of lunacy, both inside Bethel Hospital and in their communities in general. These narratives illustrate that patients' experiences could differ widely from each other depending on their gender, socioeconomic status, and the extent of their social ties. By attending to the local context of Norwich throughout this examination, we gain a better understanding of Bethel Hospital's functions within the communities it served, as well as its place within individuals' lives over the long eighteenth century. Overall, the experiences of Bethel Hospital's patients speak to multifaceted aspects of what it meant to be deemed mad in 18th-century England, showing social impacts of public discourse at a local level. They also stress the importance of considering people deemed mad not as homogenous groups, but rather as individuals with diverse origins and experiences depending on many factors including their gender, socioeconomic status, and the extent of their social networks.

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My appreciation goes out to the kind staff of the Norfolk Record Office in Norwich as well for helping me to conduct my archival research during my time there. Many thanks also to my friends and colleagues Tyla Betke and Emily Kaliel for always being willing to read my work and offer much-needed feedback and support along the way. Finally, thanks to all my friends and family for keeping me going throughout this whole journey.

Dedication

Dedicated to Doug Ruten, in memory of his supreme kindness and generosity.

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Introduction

At the dawn of the eighteenth century, but in the twilight of her life, Mary Chapman, an aging widow in Norwich, England, wrote out her last will and testament. She sought to leave behind a lasting legacy in the form of an institution designed to help some of the most vulnerable members of society. There were many labels placed upon such individuals - 'lunatics,' 'madmen,' 'the insane'[1] - but by common contemporary definition, they were individuals deemed to have lost the powers of human reason. Chapman's own reasoning for focusing on this segment of society was personal. A prominent and wealthy local figure, she explained in her will that "whereas it has pleased Almighty God to… afflict some of my closest relations and kindred with lunacy," and "in compassion to the deplorable state of such persons as are deprived of the exercise of their reason and understanding and are destitute of relations or friends to take care of them," her intention was to endow the founding of a hospital specifically for 'poor lunatics.'[2]

Chapman's stated wishes intermingled tones of charity and Christian piety. She willed that both the outside and the inside of the hospital be adorned with various Bible verses; prominent among these selections was Ecclesiastes 7:7: "Surely oppression maketh a wise man madd."[3] This institution was not only intended to take custody of the 'poor lunatics' residing within it, however. It was also meant to cure them. Thus Chapman also willed that the institution

[1] These terms, and others like them, are reiterated throughout this thesis. I use them despite their negative and stigmatizing modern connotations because these were terms commonly used in the period under discussion. To instead employ concepts such as "mental illness" in this study would project present biomedical knowledge onto the very different understandings of historical actors. It would risk presenting a misleadingly sanitized view of how people conceptualized madness in this time period, and of how individuals categorized in this fashion were treated on the basis of these understandings.
[2] Norfolk Record Office (hereafter NRO), Norwich, BH21; NRO, NCC Lawrence 216.
[3] Ibid. These verses were displayed in a frame within the hospital's boardroom as late as 1743: NRO, BH16, "An Inventory of the Goods at Bethel taken January 10: 1743."

employ a physician and an apothecary to administer treatments intended to cure the individuals under their care.[4] Her plans came to fruition in the 1713 founding of the Bethel Hospital, located in the city center of Norwich.[5] The first recorded patient of the hospital was Phillip Lewis, a poor man from Norwich who had been supported by his brother Isaac while "disordered in his senses" for five years prior to his admission to Bethel.[6] For the first time, the relatives and friends of individuals deemed mad in Norwich had an institutional option, for which there was a clear demand.

One day, almost exactly one hundred years after its founding, stark violence broke out within Bethel Hospital's walls. A patient named Jonathan Morley was mowing the grass of an inner courtyard with a scythe. A poor man originally from a parish in Suffolk, Morley had been at the hospital for nearly three years and regularly assisted in gardening duties. While he was working, the hospital's Master, James Bullard, approached him and criticized his method of cutting the grass. Morley responded by immediately attacking Bullard with the scythe, wounding him mortally.[7] This 1813 incident constitutes the most dramatic and violent example of inmates' resistance to the institutional structures of the Hospital over a century of its operation. Following Mary Chapman's 1724 death, after which the administration of the hospital fell to a public board of trustees, her benevolent designs had quickly given way to harsher realities of confinement, (mis)treatment, widespread usage of chains and other mechanical restraints, and periodic overcrowding, as the hospital expanded its facilities to confine an ever-rising patient population.

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[4] Ibid., 17.
[5] Mark Winston, "The Bethel at Norwich: An Eighteenth-Century Hospital for Lunatics," *Medical History* vol. 38 (1994), 29. The name Bethel itself was a Biblical reference, Hebrew for "House of God."
[6] NRO, BH9, Minute of 10 January 1725.
[7] *Bury and Norwich Post,* 31 March 1813, p. 3; *Norfolk Chronicle*, 3 April 1813; NRO, BH12, Minute of 26 April 1813.

This thesis examines various aspects of patients' experiences within Bethel Hospital from its founding in 1713 until roughly 1815.[8] Combining a patient-centered approach with methods of discourse analysis and select digital 3D modelling, it seeks to understand the functional and therapeutic logic of the institution, the specific effects of its policies on patients, and how patients responded to the circumstances in which they had been placed. As the hospital continually expanded its facilities over the decades, different patients confined in the hospital found both violent and non-violent means to resist the various impositions of the institution while retaining some limited autonomy. Alternately, some chose to comply with the institution and advance their own situations by acting as servants within it.

But an individual's experience of Bethel Hospital could also widely differ depend on a wide variety of factors. One's gender, socioeconomic status, and personal social networks could all play a significant role in determining their fate within the hospital. In the vein of scholars such as Geoffrey Reaume, this history seeks to understand the patients of Bethel Hospital on their own terms as persons, rather than as the diagnostic or social categories they were often reduced to by others.[9] Despite being inadvertently united by the labels of madness that their communities applied to them, the individuals confined in Bethel Hospital varied greatly in their origins, personalities and in how they responded to their confinement. Beyond binary questions of resistance or compliance with hospital staff, many of Bethel's patients managed to find small comforts in their daily lives, including each other's company, that enabled them to endure the

[8] By this latter date, the recent opening of the Norfolk Lunatic Asylum, combined with the publication of therapeutic innovations and the parliamentary uncovering of abuses in other prominent lunatic hospitals, all began to significantly change the context of Bethel's institutional provision in Norfolk: Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient, & the Family in England, 1820-1860* (Berkeley: University of California Press, 2006), 15; Winston, "The Bethel at Norwich," 27-28.
[9] Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Toronto: University of Toronto Press, 2009), 5.

trying circumstances of confinement as well as the significant stigma they faced upon discharge back into their communities. Situating these experiences within the local context of Norwich and its surrounding communities enriches our understanding of patients' lives before and after their time in Bethel Hospital, while revealing some of the personal circumstances that brought them into the institution.

Historiography

Upon its founding in 1713, the Bethel Hospital in Norwich was only the second public institution for the mad in Britain, after the infamous Bethlem Hospital (or "Bedlam") in London. Furthermore, it remained the only such institution in Norfolk for the following century, until the establishment of the Norfolk Lunatic Asylum at nearby Thorpe St. Andrews in 1814. Despite its unique history, however, to date there has been only one scholarly historical study of the Bethel Hospital. In a 1994 journal article, Mark Winston provided a largely descriptive account of the hospital's operation in order to situate its significance in the development of psychiatry. As such, his study focused on the perspective of practitioners and did not generally concern itself with the experiences of those confined and treated within the hospital.[10] Other brief mentions of Bethel Hospital in works concerning madness in England have typically focused on the unique story of its provenance, while discounting its actual significance due to its smaller scale of provision relative to other contemporary public institutions.[11]

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[10] Winston, "The Bethel at Norwich," 27-51. Other than Winston's article, the only works to date specifically regarding the hospital are a 1906 antiquarian study and a brief 1963 descriptive article: Frederic Bateman and Walter Rye, *The History of the Bethel Hospital at Norwich* (Norwich: Gibbs and Waller, 1906) ; C.V. Barclay, "An Eighteenth Century Mental Hospital," *British Journal of Psychiatric Social Work* vol. 7, no. 1 (1963): 21-26.

[11] e.g. Roy Porter incorrectly asserted on the basis of Bateman and Rye's 1906 history that the hospital never housed more than 'twenty or thirty lunatics' over the eighteenth century (this was only true prior to a major expansion of the hospital in the early 1750s), concluding that the hospital "never […] assumed any national importance." In 2004 Chris Philo provided a more nuanced assessment, although he also did

Winston's article reflects the conventional approach taken in histories of psychiatry, which dominated the historiography until around the 1960s. The foundational works in this field did not take into account the socially constructed nature of popular labels and diagnostic categories of madness. Early histories instead narrated progressivist accounts of the treatments developed in order to tame madness. Accounts such as Gregory Zilboorg's 1941 *The History of Psychological Medicine* focused particularly on the imagery of chains and whips as singular symbols of the animalistic treatment of the mad in 18th-century Britain.[12] When the chains came off, these narratives implied, oppression immediately gave way to more humanitarian moral treatment of the 19th century within asylums, followed by the steady development of the psychiatric discipline towards the scientific knowledge of the present.

These histories essentially functioned to celebrate and reinforce the practices of the present day. Zilboorg's account ended with the predominance of Freudian psychoanalysis.[13] The modern continuation of this celebratory approach is evident in the work of scholars such as Edward Shorter, who promotes a very different triumphalist narrative of psychiatry's development leading up to the dominance of biological models of mental illness.[14] Leonard Smith is another recent proponent of this conventional practitioner-focused approach to the history of psychiatry. In two books on English lunatic hospitals, Smith traced their emergence

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not take into account the hospital's continual expansion: Roy Porter, *Mind-Forg'd Manacles: a History of Madness in England from the Restoration to the Regency* (London: Penguin Books, 1990), 130; Chris Philo, *A Geographical History of Institutional Provision for the Insane From Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lewiston: Edwin Mellen Press, 2004), 446, 451.

[12] Gregory Zilbourg, *A History of Medical Psychology* (New York: W. W. Norton, 1941)

[13] Ibid., 507; Allan Beveridge, "Reading About The History of Psychiatry," *The British Journal of Psychiatry* vol. 200, no. 5 (May 2012), 431.

[14] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

with an eye towards the role of doctors and the different methods of treatment they developed within individual institutional contexts.[15] Of note is that in all of these histories there was a singular focus on the development of psychiatry and its practitioners. The experiences of the individuals historically deemed mad and subjected to these forms of treatment remained largely unexamined in the literature.

Social movements occurring in the 1960s, namely anti-psychiatry, and highly influential works such as Michel Foucault's 1961 *History of Madness*, shifted the historiographical focus away from psychiatric practitioners and towards the socially constructed nature of diagnostic categories of mental illness. These works brought attention to aspects of social control within psychiatric practice.[16] Focusing primarily on the French context, but also generalizing most of his arguments to include Britain, Foucault's 1961 work turned narratives of psychiatric progress on their head. He argued that the emergence of psychiatry was predicated on a 'Great Confinement' in the 18th century, which attempted to silence unreason by corralling the mad from society to various institutions. Second, he argued that the discontinuance of chains in favour of 'moral treatment' in 19th-century England marked a transition not to humanitarian freedom, but rather to more sophisticated technologies of restraint and discipline.[17] Foucault's provocative arguments were highly influential across many disciplines, and they helped spur subsequent historians to address, refine, and in some cases reject his claims by re-examining the history of madness in the British context. New social histories of madness analyzed the functions

[15] Leonard D. Smith, *'Cure, Comfort, and Safe Custody': Public Lunatic Asylums in Early Nineteenth-Century England* (London: Leicester University Press, 1999) ; Leonard Smith, *Lunatic Hospitals in Late Georgian England* (London: Routledge, 2007).
[16] Michel Foucault, *History of Madness,* trans. Jonathan Murphy and Jean Khalfa (New York: Routledge, 2009); R.D. Laing, *The Divided Self: An Existential Study in Sanity and Madness* (London: Penguin Books, 1969).
[17] Foucault, *History of Madness.*

of early mental institutions in terms of social control, situating the emergence of lunatic hospitals within the context of changing socioeconomic conditions in Britain.[18]

Medical historians furthered these approaches by examining the voices of those deemed mad on their own terms, rather than centering studies on the application and resistance of power in psychiatric institutions. Most pertinent to the present study, Roy Porter provided the first major survey of changing conceptions of madness across 18th-century England with his 1987 book *Mind-Forg'd Manacles.* In it, Porter provided a broad overview of the changing perceptions of madness over the 18th century while placing them in their social and cultural context. He rejected Foucault's notion that there was any "Great Confinement" of the mad in Britain in the 18th century, stressing that the actual scale of confinement in this period did not come close to what Foucault had suggested. More significantly, though, Porter adopted a patient-centered approach in the work that highlighted some of the experiences and voices of people deemed mad as revealed in contemporary literature.[19]

Another key component of Porter's monograph was the distinction he drew between increasingly specialized understandings of madness, and the wider popular understandings of madness out of which medical knowledge developed and coexisted.[20] Such distinctions inspired scholars such as R.A. Houston and Peter Rushton to move beyond mental institutions and turn

[18] Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (London: Allen Lane, 1979) ; Klaus Doerner, *Madmen and the Bourgeouisie: A Social History of Insanity and Psychiatry,* trans. Joachim Neugroschel and Jean Steinberg (Oxford: Basil Blackwell Publisher Limited, 1981).
[19] Roy Porter, *Mind-Forg'd Manacles: a History of Madness in England from the Restoration to the Regency* (London: Penguin Books, 1990).
[20] Ibid.*,* 19-20.

instead to records from legal archives and workhouses in order to get a richer sense of how early modern societies as a whole conceptualized and acted upon madness.[21]

The cultural turn led to further developments in scholarship that examined how forms of madness were constructed and represented culturally in Britain. Scholars such as Elaine Showalter and Paul Kelleher have examined cultural constructions of madness in relation to dimensions of gender and sexuality.[22] The construction of madness through discourse has formed an important focus of cultural histories. Such studies are grounded in Foucault's influential conceptualization of discourse as a system of rules, statements, and power relations governing the historical constitution of knowledge and truth within societies.[23] Instead of studying cultural representations in isolation, though, recent emerging scholarship has worked to reconcile historical discourses concerning madness with their influences on the material aspects of early institutions.[24] Others have explored the material culture of asylums by examining various aspects of their architecture and geography.[25]

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[21] R.A. Houston, *Madness and Society in Eighteenth-Century Scotland* (Oxford: Oxford University Press, 2000) ; Peter Rushton, "Lunatics and Idiots: Mental Disability, the Community and the Poor Law in North-East England, 1600-1800," *Medical History* vol. 32 (1988): 34-50.

[22] Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (New York: Pantheon Books, 1985) ; Paul Kelleher, "Reason, Madness, and Sexuality in the British Public Sphere," *The Eighteenth Century* Vol. 53, No. 3 (Fall 2012): 291-315.

[23] See e.g. Gerold Sedlmayr, *The Discourse of Madness in Britain, 1790-1815: Medicine, Politics, Literature* (Trier: Wissenschaftlicher Verlag Trier, 2011); Michel Foucault, *The Archaeology of Knowledge,* trans. A.M. Sheridan Smith (London: Routledge Classics, 2002), 120-121. In this framework of discourse, forms of madness or unreason are considered to be those which stand outside the system of permitted statements and are thus subject to practices of exclusion.

[24] e.g. Jonathan Andrews, "The (un)dress of the mad poor in England, c. 1650-1850. Part 2," *History of Psychiatry* vol. 18, no. 2 (2007): 131-156; Paul Laffey, "Two Registers of Madness in Enlightenment Britain. Part 2." *History of Psychiatry* vol. 14, no. 1 (2002): 63-81.

[25] Benoit Majerus, "The Straitjacket, the Bed and the Pill: Material Culture and Madness," in *The Routledge History of Madness and Mental Health,* ed. Greg Eghigian (Routledge, 2017): 263-276; Christine Stevenson, *Medicine and Magnificence: British Hospitals and Asylum Architecture, 1660-1815* (New Haven: Yale University Press, 2000); Katherine Fennelly, "Out of Sound, Out of Mind: Noise Control in Early Nineteenth-Century Lunatic Asylums in England and Ireland," *World Archaeology* vol. 46, no. 3 (2014): 416-430.

However, historians have not yet combined these patient-centered and sociocultural approaches in a study of a single British institution for the mad in the 18th century. These different aspects inform the approach I take within this thesis. By combining a patient-centered approach with discourse analysis and considerations of architecture, this thesis situates Bethel Hospital's operation over the 18th century within the context of both its local community and its connection to broader intellectual developments. In doing so, this thesis first builds on the specific historiography of Bethel Hospital, which is currently very limited. Further, this study also contributes to the wider historiography of how madness was constructed over time within early modern Britain, revealing the consequences shifting conceptualizations had for the day-to-day experiences of the individuals who were labeled, confined and treated on their basis.

Methodology

Consistent with social historians' preference for patients' perspectives, this history of Bethel Hospital seeks to uncover the experiences and voices of its inmates on their own terms.[26] It is important to stress, though, that these patients' perspectives have been gleaned primarily from surviving archival records created by the hospital's administrators and practitioners. The additional consultation of legal documents, contemporary newspapers, and outside visitors'

[26] Regarding terminology: Throughout this thesis I variously refer to the individuals confined in Bethel Hospital as patients, inmates, persons, and, if quoting or referencing the language of contemporary sources, lunatics. Inmate can be defined as an individual forcibly confined and/or restrained in Bethel Hospital; patient can be taken to mean an individual receiving a form of medically-oriented treatment within the hospital. These terms are not mutually exclusive. I use the terms patient and inmate interchangeably, for two reasons. First, to solely refer to these individuals as patients in the tradition of medical histories would risk reducing their existence to their role within a medical system that in this time period was only first beginning to establish itself. Second, the term inmate perhaps more accurately reflects the custodial and carceral elements of Bethel Hospital, which were always concomitant with its medical aims. I generally avoid referring to these individuals as lunatics (even though this is the term most often employed in the sources) to avoid reproducing or entrenching the severe stigma placed on these individuals for their supposed madness in their lifetimes. The underlying theoretical question at stake is how the subjects this thesis concerns might have identified themselves had they been given more of a voice in early modern English society.

accounts of the hospital also reveal further aspects of patients' experiences. But in the lack of any surviving autobiographical sources by patients, any potential insights into their lives, behaviours, and words are always intermediated by other parties who had their own biases and limited perceptions. Despite the limitations of these sources, though, they remain highly valuable for the (often elusive) insights they provide into the lives of the individuals confined and treated at the hospital.

A key assumption of this work is that in order to understand the function of an institution for the mad, it is vital to situate it in the context of its local community as well as wider cultural developments regarding how madness was perceived and treated. Therefore, this research examines the ways in which public discourses concerning madness (both popular and medical) shaped the rationales for confinement and the treatments undertaken at Bethel throughout the 18th century. To do so, it combines medical prescriptive literature, legal sources, popular literature, sermons, and other contemporary sources. As mentioned, this analysis focuses on the interplay between cultural shifts and the social dimensions of gender and poverty in the local context of Norfolk and Suffolk. By tracing patients' lives through a combination of sources, we gain a greater understanding of their experiences both during their time in the hospital and outside it, providing a more holistic picture of what it meant to be deemed mad in 18th-century England.

The first method to analyze considerations of gender involved a quantitative assessment of the rates of male and female admissions in Bethel to see how and why these ratios changed over time. In his foundational article, Mark Winston found that the ratio of women to men confined at Bethel Hospital steadily increased over the 18th century, and also that female

inmates were on average confined for shorter periods of time but more often than male inmates.[27] This thesis builds on Winston's observations by relating these shifting patterns of confinement over time to gendered aspects of contemporary discourses of madness contained in prescriptive literature. A fundamental assumption of this study is that understanding how writers discursively constructed gendered notions of madness throughout the 18th century may illuminate the gendered patterns of confinement and the gendered distribution of practices used to treat madness.

The influence of socioeconomic aspects on patterns of confinement also forms an important part of this study, particularly since Mary Chapman founded Bethel Hospital explicitly for the benefit of 'poor lunatics.' This was in accordance with the early modern rhetoric of charity surrounding the foundations of many early hospitals, which was often directed at an ideal of "the poor," a homogenous object of benevolence conceptualized out of a roughly delineated socioeconomic 'sort of' people.[28] One objective of this thesis is to determine how such rhetoric translated into social and material reality. The Hospital's records made a clear differentiation between better-off inmates whose families or friends had to pay for their institutionalization and those deemed poor enough to be kept on hospital resources. From there, one's socioeconomic status outside the hospital could indeed determine how they were treated within it.

It is equally important to include socioeconomic considerations in analyzing the discourse of madness. Early modern cultural constructions of madness, as well as the literal construction of institutions, were tightly bound up with socioeconomic factors. As historians

[27] Winston, "The Bethel at Norwich," 46-47.
[28] Adrian Wilson, "Conflict, Consensus and Charity: Politics and the Provincial Voluntary Hospitals in the Eighteenth Century." *English Historical Review* (June 1996): 599-600. Early modern hospitals' symbolism of benevolence and charity has also been emphasized by Christine Stevenson in her study of British hospital and asylum architecture: Stevenson, *Medicine and Magnificence.*

such as Andrew Scull have emphasized, it is significant that early institutions in England emerged within urban centers alongside various other institutions designed to target and discipline forms of perceived idleness.[29] As we will see, many of Bethel Hospital's poorer patients were shifted between such institutions for a large portion of their lives, sometimes for madness and other times for vagrancy or petty criminality. There were thus significant similarities between both the natures of these different institutions and the intersections of cultural constructions of madness and poverty. Understanding the socioeconomic and gendered patterns of who was confined within Bethel Hospital sheds light on how hospital administrators and practitioners took up and acted upon cultural constructions of madness at the level of local practices.

My approach of discourse analysis as a means to analyze constructions of madness is, of course, influenced by the work of Michel Foucault. I follow the approach of scholars such as Gerold Sedlmayr in moving beyond the framework initially employed by Foucault in his 1961 *History of Madness*, additionally incorporating the ideas he developed in *The Archaeology of Knowledge* concerning the ways in which historical discourses may be distinguished and analyzed.[30] Considerations of Bethel Hospital's geography, architecture, and patients' mobilities within it are influenced by the work of scholars such as Chris Philo, Christine Stevenson and Dana Arnold.[31] I have additionally employed digital methodologies to create 3D representations

[29] Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900* (New Haven: Yale University Press, 1993). This connection between the simultaneous emergence of early asylums and other penal institutions was first emphasized by Foucault, *History of Madness,* 61-62, 67.
[30] Foucault, *History of Madness*; Michel Foucault, *The Archaeology of Knowledge,* trans. A.M. Sheridan Smith (London: Routledge Classics, 2002)
[31] Chris Philo, "'One Must Eliminate the Effects of ... Diffuse Circulation [and] their Unstable and Dangerous Coagulation': Foucault and Beyond the Stopping of Mobilities," *Mobilities* vol. 9, no. 4 (2014): 493-511; Christine Stevenson, *Medicine and Magnificence*; Dana Arnold, *The Spaces of the Hospital: Spatiality and Urban Change in London 1680-1820* (New York: Routledge, 2013).

of the hospital building as the facilities were continually expanded over the first 50 years of its operation. It must be noted, however, that there were little detailed visual sources from the 18th century on which to base these models. Thus I combined various surviving maps of the hospital dating from the 19th century, representations of Bethel Hospital found in 18th-century maps of Norwich, accounts of architectural modifications contained in surviving hospital records, and recent conservation teams' surveys of the former hospital's buildings in order to reach tentative conclusions regarding the scale of the facilities in the 18th century.[32] These models are intended primarily to illustrate the general expansion of the hospital's physical space over the 18th century. With the severe limitations of the surviving sources, more detailed aspects such as the interior layout of the hospital or its exact dimensions lie far outside the scope of what the models can attempt to depict with any degree of certainty.

The concept of social control also forms a significant feature of this analysis. But I do not consider this concept in a simplistic fashion regarding all forms of social control as essentially negative and repressive. I instead follow scholars such as Jonathan Sadowsky in his work on Nigerian colonial asylums, where he employed a more nuanced approach influenced by the work of sociologists such as Allan Horwitz. Horwitz outlines four different types of social control with different degrees of ethicality, for instance recognizing the benefits and efficacy of modern therapeutic approaches within psychiatry while also conceptualizing how these practices enact forms of normative social control.[33] It is at times unhelpful to indiscriminately conflate the enforcement of social norms with immorality.

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[32] Rowenna Wood, Purcell et. al, *Bethel Hospital, Norwich Conservation Management Plan* no. 3 (September 2016). A selection of these primary sources are displayed in Appendix II.
[33] Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley: University of California Press, 1999); Allan Horwitz, *The Logic of Social Control* (New York: Plenum Press, 1990).

It also bears explaining how I consider and conceptualize mental illness in the present as I attempt to understand how it has been conceptualized in the past. To be clear, I am not adopting a hardline social constructivist view connoting a denial of the reality of mental illnesses. To do so would be to deny the experiences and suffering of people who have been afflicted by them. At the same time, however, I am not conceptualizing present diagnostic categories of mental illnesses as being objective descriptions of biological aberrations that may be recognized and applied retroactively within studies of historical actors. I am instead influenced more by discursive views of psychology such as those put forth by Rom Harré and Grant Gillett. Such views recognize the biochemical bases of mental illnesses, but at the same time stress that these illnesses are manifested, constructed and then subjectively recognized or 'diagnosed' discursively within particular sociocultural contexts.[34] Additionally, as scholars such as Jane Ussher have stressed, the sorts of personal distress that we recognize as mental illness often derive from an interrelated combination of intrapsychic, material and cultural factors, and are not therefore easily reduced to primarily biological models.[35] This being the case, analyses of how madness has been historically constructed within forms of discourse offer a vital means for understanding how perceptions of mental illness have changed over time, as well as what consequences these perceptions have had on those who have (and those who have not) been afflicted by mental illnesses.

This thesis is divided into three thematic chapters. Chapter One examines the institution's general function and the treatments Bethel Hospital's physicians employed upon patients,

[34] Rom Harré and Grant Gillet, *The Discursive Mind* (Thousand Oaks: Sage, 1994); Grant Gillet, *The Mind and its Discontents,* second edition (Oxford: Oxford University Press, 2009).
[35] Jane Ussher, "Women's Madness: a Material-Discursive-Intrapsychic Approach," in *Pathology and the Postmodern: Mental Illness as Discourse and Experience,* ed. D. Fee, 207-230 (London: SAGE Publications, 2000).

revealing how both were shaped by contemporary discourses concerning madness and mad people. It presents a picture largely of continuity, as practitioners presided over a regime of conventional humoural treatments throughout the period under study. The chapter also reveals gendered patterns of confinement that disproportionately affected women, as well as an alignment between constructions of madness and socioeconomic factors particularly impacting vagrant and otherwise 'poor lunatics.'

The second chapter explores the hospital's architecture and the theme of patient mobility. It examines both the ways in which hospital administrators daily regulated and limited patient mobilities while continually expanding the facilities, and in turn, the ways in which patients were able to continually resist, subvert or transcend these limitations. It additionally employs 3D modelling to attempt to visually depict the hospital's expansion over time, as a means to better historicize patients' spatial experiences of the institution.

Chapter Three further examines patient experiences and identities. It first explores themes of inmate resistance and compliance within the hospital. Personal expressions of autonomy variously took the form of escape attempts, physical resistance to restraint and confinement, and for a select few, exploiting opportunities for self-advancement within the institution by agreeing to undertake domestic employment. These distinctions complicate the simplistic separation often drawn up between patients and hospital staff by modern scholars. They are also notably revealing of the contradictions between the Hospital's stated purposes (to simply cure and discharge its patients) and its actual administration.

Beyond questions of power, the chapter also reveals more subtle aspects of patients' experiences within and without the hospital. Ways in which patients were able to find daily comforts to endure the harsh conditions of confinement, for instance, included their views of the

outside world as well as their social relations with each other. Finally, to attain a richer understanding of their experiences, the chapter examines aspects of patients' lives before and after their confinement in Bethel Hospital and the circumstances which brought them there. Dimensions of gender and socioeconomic status are again seen to have exerted considerable influences on why individuals were deemed mad and how their communities subsequently treated them.

The concept of stigma also plays a considerable role in this analysis. As we will see, to have been confined in Bethel Hospital as a 'lunatick' could leave an indelible mark on a person's social status once they returned to their communities, encouraging subtle forms of exclusion as well as outright harassment. Luckily, at least some of Bethel Hospital's former patients were able to rely on social ties they had formed with each other to endure the social (and economic) challenges of re-integrating into an often hostile wider society after confinement. Others, however, were less fortunate. Many suicides by patients in confinement testify to the profound suffering they experienced in a likely combination of intrapsychic and external negative influences. Thus overall, a patient's experience of Bethel Hospital could vary widely depending on a multiplicity of factors, underlining the importance of considering them not as a homogenous group, but rather as individual people with their own elusive origins, capabilities, and stories. Despite the difficulties of doing so, this thesis seeks above all to highlight these long-forgotten stories of the many people who passed in and out of Bethel Hospital over the long 18th century.

1

Discourses of Madness and Practices of Treatment

> […] *And whereas it hath Pleas'd Almighty God to visit & afflict some of my nearest Relations & kindred with Lunacy […] & in compassion to the deplorable state of such Persons as are depriv'd of the Exercise of their reason & understanding & are destitute of Relations or friends to take care of them […] My Will is that the House I have lately built […] be used & employ'd for the convenient reception & habitation of poor Lunaticks.*[1]
>
> — Mary Chapman, 1713

> *In vain will it be to direct our Discourse to such persons. I hope none here present are of that Number.*[2]
>
> — Reverend John Francis, Norwich, 1749

Bethel Hospital was founded against a backdrop of intermingled religious and somatic understandings of madness in the early eighteenth century. Therefore, to more fully understand and discuss the practices of treatment employed at Bethel Hospital, it is instructive to first consider the perceptions of madness contained in both popular and medical discourse throughout the 18th century which shaped these practices. Besides the more obvious importance of medical prescriptive literature to the practices of the hospital's physicians, the additional examination of contemporary non-specialist publications, legal sources and literature in this study helps to contextualize the function of the institution more generally. As we will see, popular and medical forms of discourse borrowed from each other and intermingled quite frequently throughout the long 18th century in their conceptualization of both madness and its sufferers.

[1] NRO, BH21, 14-16.
[2] John Francis, *Sermons Preached on Several Occasions, at the Cathedral in Norwich* vol. 1 (London: Thomas Miller, 1773), 88.

In particular, both experts and non-experts advanced models based upon the causative effects of the bodily humours and the passions to explain madness in this period, with some simultaneously drawing on religious etiologies. These constructions of madness significantly overlapped with factors of gender and socioeconomic factors particularly targeting poor and landless individuals. In turn, these cultural constructions shaped the founding of Bethel Hospital. Mary Chapman's last will framed the foundation of Bethel in the religious language of piety and charity specifically to benefit "poor Lunaticks."[3] Subsequently, the Hospital's practitioners persisted in following conventional somatic humour-based models in the treatment and management of their patients. Despite significant therapeutic developments in England during the latter two decades of the period under consideration, it is unlikely that such developments significantly influenced the practices of Bethel Hospital's physicians. However, a few individual efforts to change aspects of patients' treatment in the hospital briefly hinted at the potential for therapeutic advances to take place before being negated by other hospital administrators. Additionally, increasingly gendered patterns of confinement at Bethel Hospital, namely the increasingly disproportionate confinement of women, were also roughly in accordance with gendered constructions of madness formulated by medical writers. Overall, therefore, the patterns of the Hospital's practices from its founding in 1713 to 1815 were roughly consistent with similar contemporary institutions and the wider trends of prescriptive literature.

1.1 Meanings of Madness in Eighteenth-Century Britain

Mary Chapman framed the purpose of Bethel Hospital in her will using overtly religious language steeped in the rhetoric of charity. She invoked a common understanding of lunacy as an

[3] NRO, BH21, 16.

affliction visited upon individuals by the will of God inviting the contemplation and gratitude of those left in possession of their sanity.[4] Similar views explaining lunacy in terms of divine providence are seen in some contemporary legal descriptions of suicides; one 1728 coroner's inquest describes a Norwich man who killed himself as "being greatly Afflicted by ye Hands of Almighty God with Severall Distempers and […] much discomposed in his mind."[5]

More widespread in the 18th century, however, were views which likened lunacy to either demonic possession or a moral failing of the individual. For instance, in a 1759 sermon James Ibbetson proclaimed to a London congregation that "Whether we call them that were possessed in this manner by the names of Dæmoniacks or Madmen […] the symptoms […] of both are much the same."[6] Suicides were interpreted along similar lines; some 18th-century coroner's inquests into Norwich suicides described the deceased as having committed the act "not having the feare of God before [their] Eye and through ye Instigation of the Devil."[7]

Perceptions of what was termed melancholy often contained moralistic overtones. Seventeenth-century clergyman Richard Baxter supposed the condition to derive from "Sinful Impatience, Discontents and Cares, […] from want of sufficient Submission to the will of God."[8] Such moralist views were not by any means limited to religiously framed formulations of madness, however. As Joy Wiltenburg concluded in her study of street ballads, early modern

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[4] Ibid., 14-16.
[5] NRO, NCR6a/5/25.
[6] James Ibbetson, *The Case of Incurable Lunaticks, and the Charity due to them, particularly recommended* (London: J. Whiston and B. White, 1759), 14.
[7] e.g. NRO, NCR 6a/5/42 (1730 inquest of Ann Letree); NCR 6a/5/20 (1727 inquest of Philip Letree); NRO, NCR 6a/8/43 (1754 inquest of Thomas Gray); NRO, NCR 6a/42/32 (undated draft inquest of Richard Bell). This standard phrasing dates back to at least the 16th century: M. MacDonald and T.R. Murphy, *Sleepless Souls. Suicide in Early Modern England* (Oxford: Clarendon Press, 1990), 55.
[8] Richard Baxter, *The Signs and Causes of Melancholy (1716),* in *Patterns of Madness in the Eighteenth Century: A Reader* ed. Allan Ingram (Liverpool: Liverpool University Press, 1998), 44.

popular perceptions of madness, whether religious or secularly minded, tended to ultimately place the blame upon individuals for the apparent failure of their reason.[9] Culturally, the "Mad-man and the Fool" stood side-by-side as archetypes of otherness, figures commonly employed in satirical works to represent socially aberrant behaviours inviting either scorn or pity.[10]

Popular cultural constructions of madness and moral judgements of its sufferers were also notably influenced by socioeconomic factors. In particular those who were both poor and deemed mad were criticized for their perceived idleness.[11] Poverty featured prominently in cultural perceptions of madness; Ibbetson's sermon characterizes 'incurable Lunaticks' as those who "are furious and raving […] and are moreover poor and cannot otherwise be provided for."[12] So-called nervous conditions such as melancholy, on the other hand, were often associated with individuals of higher status and were thought to derive from passions attending excesses of wealth and luxury, constituting (as Roy Porter has argued) a more socially acceptable form of madness.[13] Thus one's social status could profoundly influence how their apparent madness might be judged and responded to.

Particularly under the Elizabethan Poor Law and in the urban context of Norwich,[14] though, the perception of lunacy was bound up with the indictment of vagrancy, which was often

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[9] Joy Wiltenburg, "Madness and Society in the Street Ballads of Early Modern England," *Journal of Popular Culture* vol. 21, no. 4 (Spring 1988), 122.
[10] *A Description of Bedlam. With an Account of its Present Inhabitants …* (London: Printed for T. Payne, 1722), 30; Laffey, "Two Registers of Madness in Enlightenment Britain. Part 2," 65; Roy Porter, *Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900* (London: Reaktion Books, 2001), 94.
[11] Anne Digby, *Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914* (Cambridge: Cambridge University Press, 1985), 3.
[12] Ibbetson, *The Case of Incurable Lunaticks,* 12-13.
[13] e.g. Thomas Arnold, *Observations on the Nature, Kinds, Causes, and Prevention of Insanity, Lunacy, or Madness volume I* (Leicester: G. Ireland, 1782), 17; Roy Porter, *Mind-Forg'd Manacles*, 82, 84.
[14] Norwich was one of the first major cities in Britain outside of London, reaching a population of about 29,000 by the mid-1690s: Alan Armstrong, "Population: 1700-1950," in *Norwich Since 1550,* eds. Carole Rawcliffe and Richard Wilson (London: Hambledon and London, 2004), 244.

framed as a public danger. As Edgar Miller has revealed, wandering pauper lunatics without occupations were particularly visible for their lack of fixity, and were thus increasingly targeted for confinement in workhouses on grounds of vagrancy in the long 18th century.[15] Confinement of such individuals served dual functions to target idleness and to reduce the visibility of madness in the public sphere. One such case in Norwich was that of Joseph Donne, who in 1749 was reported to be "a Lunaticke" that was "apprehended[…] as a Rogue & Vagabond (Namely) wandering begging & asking aboutt the streets in the open air to the danger of the Inhabitants" and ordered to be removed back to his parish of origin.[16]

This aim to hinder the mobility of wandering lunatics notably undergirded Mary Chapman's invocation of "poor Lunaticks" as the ideal object of her charitable foundation. She stressed that "Such Lunatick [per]sons […] shall be kept Close & not suffered to wander abroad during their Disorder" until it abated. Such a policy would sequester the feared public danger of the 'lunatic' during the course of their affliction and secure the conditions essential for their treatment to commence.[17] But this physical segregation of mad people from their communities also engendered a language of otherness that downplayed or outright denied their human subjectivity, their status as individuals worthy of being regarded as and interacted with as people. In 1749, Reverend John Francis gave a sermon on the subject of 'self-murder' at St. Peter's Mancroft church in Norwich, a mere block away from Bethel Hospital. After first stressing the 'Weakness' of people that commit suicide in response to hardships in life, Francis briefly turned his attention to those who would commit the act in a state of lunacy. He asserted that

[15] Edgar Miller, "English Pauper Lunatics in the Era of the Old Poor Law," *History of Psychiatry* vol. 23, no. 3 (2012), 320, 324.
[16] NRO, CASE 15c/1/25.
[17] NRO, NCC will register Lawrence 219; Philo, "'One Must Eliminate the Effects of ... Diffuse Circulation [and] their Unstable and Dangerous Coagulation', 495.

> the Soul, when under this Disorder, turn[s] all the Lessons of Reason and Religion against itself […] in vain will it be to direct our Discourse to such persons. I hope none here present are of that Number.[18]

Here, after conceptualizing madness as a disorder of the soul setting an individual wholly apart from reason and religion, Francis explicitly set mad people apart from the community he was addressing. In practice, Bethel Hospital would perform a similar function.

1.2 The Perceptions of a Burgeoning Medical Field

Such popular perceptions of madness reflected the changing understandings of medical practitioners operating in various clinical and institutional contexts throughout the 18th century. The fundamental medical models of madness in the early modern period were based upon the idea of the balance of four bodily humours (blood, yellow bile, black bile, and phlegm), dating back to the ancient Greeks.[19] Madness was traditionally divided into Melancholia, characterized by 'moping' or excessive inactivity, and Mania, said to be characterized by "a most raging involuntary Fury." Which form madness would take was thought to depend on the humoural constitution of the individual, i.e. which bodily fluid was thought to predominate and shape their physical disposition.[20]

By the early 18th century, the discovery of the nervous system had influenced medical perceptions of madness,[21] although the ingrained humoural theories were not quickly discarded in consequence. In 1722 Nicholas Robinson explained the common theory of madness's origins

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[18] Francis, *Sermons Preached on Several Occasions,* 84, 88.
[19] Arnold, *Observations on the Nature, Kinds, Causes, and Prevention of Insanity,* 29, 37.
[20] Nicholas Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy: Wherein all the Decays of the Nerves, and Lownesses of the Spirits, are mechanically Accounted for* (London: A. Bettesworth, W. Innys, and C. Rivington, 1729), 199.
[21] Porter, *Mind-Forg'd Manacles,* 47.

in the passions in terms of a "fine Animal Aether" determined by one's humoural constitution, a bodily malady requiring bodily treatment.[22] Indeed, the explanation of madness originating in the over-indulgence of human passions was a common part of somatic explanations, forming what historian Paul Laffey has termed the "moral register" of madness.[23] Later medical writers such as William Battie agreed that passions could be excited into madness by "unwearied attention to any one object,"[24] with 'love madness' being the most commonly cited example.[25] Religious figures shared these views, warning that "The Passions […] oftentimes overset the Mind and make a shipwreck of Reason."[26]

In accordance with the distinction contemporaries drew between base passions and reason, the singularly human attribute, many medical constructions represented the mad as animalistic. Mythical attributes of superhuman strength and supposed imperviousness to cold were ascribed to mad patients by Robinson early in the century, and were still being reiterated in the early 1800s.[27] Mad-doctor Joseph Mason Cox even went so far as to assert in 1806 that to certify madness, testing the subject's capability to resist "heat, cold, hunger, thirst, drastic remedies, watching, fatigue, &c. is decisive."[28] In pre-eminent mad-doctor John Monro's 1758 reply to Battie's treatise on madness, he argued that cases of "animalistic" madness he had

[22] Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy*, 79.
[23] Paul Laffey, "Two Registers of Madness in Enlightenment Britain. Part 1," *History of Psychiatry* vol. 13, no. 1 (2002), 371.
[24] William Battie, *A Treatise on Madness* (London: K. Whiston and B. White, 1758), 85.
[25] e.g. William Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases; Apoplexy and Palsy…* (London: C. Nourse, 1788), 271; Joseph Mason Cox, *Practical Observations on Insanity; In which some Suggestions are offered towards an improved Mode of treating Diseases of the Mind,* 2nd ed. (London: C. and R. Baldwin, 1806), 20.
[26] Ibbetson, *The Case of Incurable Lunaticks,* 7.
[27] Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy,* 221, 242; e.g. John Johnstone, *Medical Jurisprudence on Madness* (J. Belcher: Birmingham, 1800), 20.
[28] Cox, *Practical Observations on Insanity,* 207.

witnessed as a physician to Bethlem Hospital constituted "the total suspension of every rational faculty."[29] Such judgements, similarly to those of contemporaries outside the medical field, effectively equated the mad to "the brute creation," indirectly endorsing a paternalist stewardship over their welfare.[30]

Winds of change first came with the influence of John Locke, who conceptualized madness not as Reason's irreducible opposite, but instead as a mistaken form of reasoning that may be corrected. His focus on mistaken notions or ideas notably rooted madness entirely in the soul rather than the body.[31] Locke's concepts, part of his more general theorization of human understanding, had a notable influence upon William Battie's binary formulation of Original and Consequential Madness, the former said to be a 'deluded imagination' deriving from internal causes and the latter from external causes.[32] In his reply to Battie's 1758 treatise, John Munro attempted to refute this definition, arguing madness to consist of a morally "vitiated judgement."[33] In 1782 Thomas Arnold effectively combined both of these formulations by defining madness as conditions where the mind's "imagination is disturbed […] and its judgement is depraved."[34] Arnold delineated yet another binary division of madness, this time into 'ideal' and 'notional' insanity — the former rooted in errors of perception (e.g. hallucinations), the latter consisting of errors of reasoning conducted by the individual will.[35] This latter distinction echoed Locke's 1690 assertion that 'mad men' had not lost the faculty of

[29] John Monro, *Remarks on Dr. Battie's Treatise on Madness* (London: Printed for John Clarke, 1758), 6.
[30] Ibbetson, *The Case of Incurable Lunaticks,* 9-10; Keith Thomas, *Man and the Natural World: a History of the Modern Sensibility* (New York: Pantheon Books, 1983), 155, 180.
[31] Laffey, "Two Registers of Madness in Enlightenment Britain. Part 1," 368, 375.
[32] Laffey, "Two Registers of Madness in Enlightenment Britain. Part 2," 70; Peter R. Antsey, "Locke and the Philosophy of Mind," *Journal of the History of Philosophy* vol. 52 no. 2 (April 2015), 236.
[33] Monro, *Remarks on Dr. Battie's Treatise on Madness,* 4.
[34] Arnold, *Observations on the Nature, Kinds, Causes, and Prevention of Insanity,* 14.
[35] Laffey, "Two Registers of Madness in Enlightenment Britain. Part 2," 71-72.

reasoning entirely, but rather joined ideas together 'wrongly.'[36] Thus Locke's concept of a madness based within reason slowly merged with existing explanations and at times was employed alongside them.

Starting as early as the 1750s, these theories of moral or mental causation fomented a slow shift toward predecessors of what was eventually termed 'moral treatment,' although such forms of treatment remained controversial for their opposition to the principles of conventional humoural treatment.[37] Robert Whytt was one early advocate of a mind-based form of treatment, proposing in 1765 that to treat melancholy without an apparent somatic cause, "nothing has done more service than agreeable company […] and a variety of amusements."[38] Similarly, in a 1788 treatise on hysteria, William Rowley asserted that "The cure of the mental wretchedness depends much on the soothing, reasoning, and the consolation of affectionate friends," and further advised that "*Tactiturnity and meditation* should be conquered by engaging the patient to converse on favorite subjects."[39] The slow development of such intersubjective approaches, advocating that mad people may be profitably talked to and reasoned with, evinced an increased recognition of their common humanity.

These practices of treatment shortly anticipated the Tukes' famous development of 'moral treatment' at the York Retreat in the 1790s.[40] The Tukes notably argued for the cessation

[36] Louis C Charland, "John Locke on Madness: Redressing the Intellectualist Bias," History of Psychiatry vol. 25 no. 2 (2014), 141-142. John Haslam similarly distinguished between physical and moral causes of madness in a 1798 work: John Haslam, *Observations on Insanity* (London: F. & C. Rivington, 1798), 99-100.
[37] Laffey, "Two Registers of Madness in Enlightenment Britain. Part 2," 74.
[38] Robert Whytt, *Observations on the Nature, Causes, and Cure of those Disorders which have been Commonly called Nervous, Hypochondriac or Hysteric* (Edinburgh: J. Balfour, 1765), 520.
[39] Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases,* 228-229.
[40] Laffey, "Two Registers of Madness in Enlightenment Britain. Part 2," 75.

of conventional somatic treatments, by 1813 asserting that "If we adopt the opinion, that the disease originates in the mind, applications made immediately to it, are obviously the most natural."[41] Besides being based around the interpersonal engagement of the patient, the Tukes' moral treatment also contained a central focus on practices of religion, including regular divine service and attempts to foster a sense of close spiritual community between its (exclusively Quaker) patient population through formalized socializing.[42] The practices of moral treatment developed at the York Retreat proved highly influential, with its innovations shaping practices at many institutions in the following decades.[43] Some remained unconvinced, however, instead emphasizing the singular authority of mad-doctors over their patients. In 1806 Joseph Mason Cox, echoing the 'us and them' sentiments of popular opinion, summarized the conventional wisdom long employed by contemporary mad-doctors: "the talking *at* will be found more efficacious than talking *to* a patient."[44]

1.3 Madness and Gender in the Medical Purview

Medical constructions of madness also overlapped considerably with gendered considerations particularly targeting women. Perhaps the most prominent example is seen in the gendered construction of hysteria throughout the 18th century. The English term "hysteria" began to replace terms such as 'the Vapours' in the 1760s, following the French example.[45] A

[41] Samuel Tuke, *Description of The Retreat, an Institution Near York, for Insane Persons of the Society of Friends* (York: W. Alexander, 1813), 132.
[42] Leonard D. Smith, *'Cure, Comfort, and Safe Custody*,' 209; Porter, *Mind-Forg'd Manacles,* 223-224.
[43] Ibid., 212-213.
[44] Cox, *Practical Observations on Insanity,* 45; Laffey, "Two Registers of Madness in Enlightenment Britain. Part 1," 294.
[45] Sabine Arnaud, *On Hysteria: The Invention of a Medical Category between 1670 and 1820* (Chicago: University of Chicago Press, 2015), 26.

malady first said to exclusively afflict women, it was contended to cause an imbalance in bile that must be depleted from the body with purgatives.[46] In a 1788 treatise, William Rowley lists among the common 'constitutional causes' of hysteric disorder "a delicate and tender hereditary structure of the body," "Great natural earnestness on all occasions, and extreme sensibility of the mind," and "High-scented perfumes."[47] Such explanations contain a notable gendered construction of madness as feminine or proceeding from perceived feminine traits, in a culture where women's 'sensibility' was posited to be more delicate and prone to 'bad nerves' than that of men.[48] Simultaneously, they also suggest a significant policing of gender roles, particularly seen in the condemnation of "Great natural earnestness on all occasions." One 18th-century dictionary defined earnestness as consisting of "eagerness; warmth; vehemence."[49] In contemporary discussions of male figures, the specific trait of 'natural earnestness' typically had a very positive and, significantly, active connotation, for example being listed among the traits of great orators which "have mighty influence on the Heart and Mind of the Hearer."[50] The assertion that women displaying the same active trait "on all occasions" could end up in the throes of hysteria suggests that it was only deemed acceptable in certain circumscribed social contexts, for instance motherhood: one 1782 publication praises the "natural earnestness of a mother."[51] It is significant that social behaviour straying from perceived female gender roles was

[46] Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases,* 86.
[47] Ibid., 56.
[48] Allan Ingram and Michelle Faubert, *Cultural Constructions of Madness in Eighteenth Century Writing: Representing the Insane* (New York: Palgrave Macmillan, 2005), 137.
[49] Samuel Johnson, *A Dictionary of the English Language,* third edition (Dublin: W. G. Jones, 1768), s.v. "EARNESTNESS."
[50] John Lawson, *Lectures Concerning Oratory* (Dublin: George Faulkner, 1758), 426; Jacob Hooper, *An Impartial History of the Rebellion and Civil Wars in England* (London: 1738), 42.
[51] *The European Magazine and London Review Volume 1* (London: Philological Society of London, 1782), 407.

framed as not only symptomatic of madness, but causative of madness. Doctors such as Robinson argued that hysteria, if left untreated, would progress into madness proper,[52] an impetus for confinement and treatment of perceived madwomen.

Elaine Showalter's findings that 19th-century psychiatrists thought women to be susceptible to madness at higher rates due to their reproductive systems' supposed tendency to interfere with their rationality appears to generally hold true for 18th-century writers as well.[53] Discussing the generally higher rates of female admissions in private madhouses, John Haslam proposed that

> The natural processes which women undergo, of menstruation, parturition[i.e. childbirth], and of preparing nutriment for the infant, together with the diseases to which they are subject at these periods, and which are frequently remote causes of insanity, may, perhaps, serve to explain their greater disposition to this malady.[54]

Medical authorities considered constitutionally "delicate and irritable females" to be especially prone to madness following childbirth.[55] This is likely based upon observations of conditions similar to what we would now describe as post-partum depression or psychosis, but nonetheless the way it is constructed here reflects medical perceptions of a supposed inherent weakness of the female body and mind.[56] Monro (c. 1758) and Whytt (c. 1765) also argued 'suppression of the menses' to be a major cause of madness among women, while Rowley additionally spoke of a "milky mania" occasioned by the suppression of milk secretion.[57]

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[52] Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy,* 199.
[53] Elaine Showalter, *The Female*, 55.
[54] Haslam, *Observations on Insanity,* 282.
[55] Johnstone, *Medical Jurisprudence on Madness,* 16.
[56] One 18th-century case retrospectively suggested to fit the profile of post-partum depression is outlined in Carol Percy, "Writing from the Asylum: Martha Shakespear Lloyd at the Linguistic Limits of eighteenth-century Femininity," *Women's Writing* vol. 13, no. 1 (2006), 102.
[57] Monro, *Remarks on Dr. Battie's Treatise on Madness,* 32; Whytt, *Observations on the Nature, Causes, and Cure of those Disorders which have been Commonly called Nervous, Hypochondriac or Hysteric,* 519; Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases,* 282.

By the 1780s madness itself was sometimes constructed in opposition to masculinity as a feminine indulgence of the passions, over-passivity or an inability to contain one's emotions.[58] For instance, Thomas Arnold supposed causes of 'phrenetic insanity' (a kind of mania) to include "the distress of disappointed love, inconsolable grief, religious despair, or any other of the desponding, and *unmanly affections*" (emphasis added).[59] The indulgence of emotions was presented in opposition to the gendered concept of male rationality. In fact both hysteria and its male equivalent, hypochondria, were constructed as feminine; as Sabine Arnaud has argued, medical texts presented "male vapors as the result of a man's feminization" deriving from a general "feminization of manners."[60] In light of these constructions, it is significant that by 1800 English medical men were confidently asserting that "The female in our climate is said to be more frequently affected by this disorder of the understanding [i.e. insanity] than the male sex."[61] As will be detailed below, surviving evidence from Bethel Hospital similarly suggests that women made up approximately two-thirds of the patient population by the latter half of the period under discussion. It appears that, in spite of the arguments of historians such as R.A. Houston that 18th-century writers did not present madness as "a product of women's 'nature'" and that "there was no uniquely female construct of madness,"[62] madness indeed proved to be 'the female malady'[63] in certain respects throughout the 18th century.

[58] Ingram and Faubert, *Cultural Constructions of Madness in Eighteenth Century Writing,* 137.
[59] Arnold, *Observations on the Nature, Kinds, Causes, and Prevention of Insanity,* 135; despair was similarly painted as "the most unmanly" by lay writers, e.g. *A Description of Bedlam*, 44.
[60] Arnaud, *On Hysteria,* 21.
[61] Johnstone, *Medical Jurisprudence on Madness,* 5-6.
[62] R.A. Houston, "Madness and Gender in the Long Eighteenth Century." *Social History* vol. 27, no. 3 (October 2002), 316, 325. Houston's article is largely positioned as a critique of Showalter.
[63] To borrow Showalter's phrase.

1.4 Combating Madness: Practices of Treatment at Bethel Hospital, 1724-1813

In institutional environments, the treatment of madness was intimately connected with forms of what was termed management, means for administrators to physically exert authority over patients and ensure the docility of their bodies within the nascent asylum to allow treatments to commence. The eminent mad-doctor at Bethlem Hospital in London, John Munro, described the fundamental principles of management as consisting of confinement, the establishment and maintenance of authority over patients, and obliging them to observe "great regularity in their hours."[64] Michel Foucault termed such methods forms of "psychiatric power" which allowed the production of psychiatric knowledge; it has also been described as "charismatic stewardship," an ethos of dominating behaviour by which mad-doctors asserted their authority over patients.[65] John Monro notably argued management to be more efficacious in treating madness than what he characterized as "the less important part of medicine," a sentiment also echoed later by Joseph Mason Cox.[66]

But as historians such as Leonard Smith and Mike Jay have noted, the conventional medical treatments of humour-based models of madness, consisting largely of bloodletting, purging and emetics, could in practice be similarly aimed at quelling resistance among patients.[67] Indeed, contemporary mad-doctors explicitly valued such treatments for their violent effects upon the body and mind; for treating Lunacy, Nicholas Robinson recommended

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[64] Monro, *Remarks on Dr. Battie's Treatise on Madness,* 37-39.
[65] Foucault, *Psychiatric Power,* 173-174; Laffey, "Two Registers of Madness in Enlightenment Britain. Part 1," 294; such behaviour was outlined by mad-doctor Joseph Mason Cox as consisting of "A firm, resolute demeanor, stern aspect, an assumption of authority […] a scrutinizing look fixed on the patient's eye, will, in general, excite dread or confidence, respect and compliance." Cox, *Practical Observations on Insanity,* 76.
[66] Monro, *Remarks on Dr. Battie's Treatise on Madness,* 37; Cox, *Practical Observations on Insanity,* 68.
[67] Smith, '*Cure, Comfort, and Safe Custody,'* 198; Mike Jay, *The Influencing Machine: James Tilly Matthews and the Air Loom* (London: Strange Attractor Press, 2012), Kindle edition, ch. 2.

> a Course of Medicines of the most violent Operation; and if that be not sufficient to bring down the Spirit of these Stubborn Persons, we must endeavour to reduce their artificial Strength by compulsive Methods.[68]

In 1758 Battie likewise prescribed vomits and cathartics "to shake the whole solid frame" of the patient.[69]

The physicians at Bethel Hospital employed similar treatments based upon humoural models throughout the period under discussion. Surviving hospital accounts only record specific treatments starting in 1795, and records from that time on are very sporadic, but bleeding was likely performed at the hospital from a very early date. The hospital's first board-appointed physician, Sir Benjamin Wrench (who acted in that capacity from 1724 until 1747),[70] was later reported to have been influenced by witnessing another physician's use of bleeding as a treatment for vertigo.[71] Bleeding was also reportedly used by Dr. John Beevor (who practised at Bethel c. 1758-1808) in his private practice to treat the madness of the Earl of Orford in 1777.[72] By the 1770s, the Bethel Masters' disbursements notably include expenses for purchasing "Physic Cups" most likely used for bloodletting.[73]

In the scant evidence of explicitly recorded treatments, at least four reported bleedings were conducted at Bethel Hospital from 1795-1796 (three on female patients), and two more in 1812.[74] By this later period bleedings appear to have been less frequently employed than other humoural treatments. Purging medications take up a much larger portion of the recorded

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[68] Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy,* 400.
[69] Battie, *A Treatise on Madness,* 92.
[70] Winston, "The Bethel at Norwich," 32, 45.
[71] Benjamin Gooch, *The chirurgical works of Benjamin Gooch, surgeon: in three volumes* (London: Printed for J. Johnson, 1792), 286.
[72] Jonathan Andrews and Andrew Scull, *Undertaker of the Mind: John Munro and Mad-Doctoring in Eighteenth-Century England* (Berkeley: University of California Press, 2001), 135, 137; Winston, "The Bethel at Norwich," 46, 49.
[73] NRO, BH6, e.g. Master's Disbursements for 8 March-5 April 1777.
[74] NRO, BH1170/9; NRO, BH1170/10; NRO, 1181/3/5.

treatments at Bethel Hospital. Numerous purging salts, draughts, mixtures, as well as specific herbal treatments recommended by contemporaries for their purgative properties (such as Turkey Rhubarb and 'Hera Piera'), were administered at the hospital in the periods of 1795-96 and 1798-99.[75] Many diaphoretic mixtures (substances to promote sweating) were also administered during the same period, more than thirty in total. In cases of madness, diaphoretics were particularly used to treat mania.[76]

Emetics or 'vomits' were also employed occasionally in this later period, but much less frequently than purges or diaphoretics, reflecting concurrent trends in prescriptive literature. Sixteen total emetic treatments are recorded across the periods of 1795-96, 1798-99, and 1819, with the bulk occurring in the earlier periods.[77] This trend is in line with contemporary medical publications, which from the 1780s on increasingly discarded the use of vomits as ineffective and even harmful in treating madness.[78] There were a few holdouts, however, such as mad-doctor Joseph Mason Cox who continued to recommend vomits as the most effective medical treatment of madness in 1806.[79] The continued, although sporadic, use of emetics as late as 1819 in Bethel suggests a slowness to respond to trends contained in the literature, but there is no evidence that vomits held an unusually prominent place in its physicians' practices overall.

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[75] NRO, BH1170/9; NRO, BH1170/10; Turkey Rhubarb was used as a "gentle purgative," but also as an astringent in cases of hypochondria/hysteria: Abraham Rees, *The Cyclopaedia; Or, an Universal Dictionary of Arts, Sciences... Volume 30* (London: Longman, Hurst, Rees, Orme, & Brown, 1819), s.v. "Rhubarb."; Renodaeus, *A Medicinal Dispensatory, containing the whole body of physick…*, trans. Richard Tomlinson (London: John Streater and John Cottrell, 1657), 567-568.
[76] NRO, BH1170/9; NRO, BH1170/10; NRO, BH1532; William Rowley, *A Treatise on Madness and Suicide…* (London: J. Barfield, 1804), 83.
[77] NRO, BH1170/9; NRO, BH1170/10; NRO, BH1178/1. No emetics are included among the reported treatments from 1810 and 1812.
[78] Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases,* 245; Haslam, *Observations on Insanity,* 143.
[79] Cox, *Practical Observations on Insanity,* 102.

Alteratives, substances ingested to "change the humours or juices from a state of distemperature to health,"[80] were one of the most commonly and consistently administrated treatments at Bethel. Over the periods of 1795-96 and 1798-99, more than 60 alterative powders and pills were administered.[81] Notably, alteratives were recommended by writers for cases of hysteria with a poor prognosis; for instance, William Rowley advised that in such cases "a long course of mild alteratives should be instituted, and long continued."[82] It remains unclear, however, whether alteratives were used at Bethel Hospital primarily for hysteric complaints or used also to treat other conditions. Another treatment without a clear function is sulphur, which was administered at least twice in Bethel Hospital from 1795-96.[83] Later in the 19th century sulphur was used in conjunction with other medicines to treat both mania and melancholy,[84] but whether it served a similar function in the late 18th century remains unknown.

It is clear, however, that the physicians at Bethel Hospital attempted to treat many cases perceived as nervous disorders, especially under the practice of Dr. John Manning. At least 27 doses of "Nervous Pills" or powders were administered under Manning from 1795-96.[85] Additionally, there are semi-regular appearances of "Spirit of Hartshorn" in the records in 1796, 1798, 1810 and 1811.[86] Spirit of Hartshorn consisted of powdered deers' antlers made into a 'volatile liquor,' and was used in this period to treat hysteria as well as melancholy.[87] 'Astringent

[80] John Bartlet, *The Gentleman's Farriery: or, a Practical Treatise on the Diseases of Horses* (London: John Nourse, 1753), 188.
[81] NRO, BH1170/9; NRO, BH1170/10; NRO, BH1532.
[82] Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases,* 116.
[83] NRO, BH1170/9.
[84] Samuel Worcestor, *Insanity and its Treatment* (New York: Boericke & Tafel, 1882), 165.
[85] NRO, BH1170/10.
[86] NRO, BH1170/9; NRO, BH1156; NRO, BH1178/3; NRO, BH1554.
[87] Richard Reece, *The Medical Guide,* ninth edition (London: Longman, Hurst, etc., 1813), 13; Robert Dossie, *The Elaboratory Laid Open,* 2nd edition (London: J. Nourse, 1768), 97.

Mixtures' were also likely used to treat nervous complaints and were administered many times at Bethel Hospital, especially from 1810-1811.[88] In William Battie's influential 1758 work, he theorized that medicines with astringent properties aid in treating "consequential anxiety" by returning the nerves to their "natural firmness."[89] There is also an isolated reference in the 1795 records to "Chamomile Flowers," an herb recommended by medical writers to treat hysteria.[90]

This apparent focus on treatments of nervous disorder, including hysteria, revealed by the hospital's records is particularly significant in the context of both the gendered constructions of madness already discussed, and an increasingly disproportionate representation of women among the patient population in Bethel Hospital as it expanded over the course of the long 18th century. In 1771 the board ordered that the hospital facilities expand to accommodate 33 female and 22 male patients, constituting a 60% female population. At the time of this order, the hospital held 50 patients in total (gender demographics of patients were not specified in this period).[91] By 1810, the hospital held 52 female patients and 23 male, constituting a 69% female and 31% male population respectively.[92] The exact reasons behind this disproportionate female population are difficult to parse, likely deriving from a combination of various cultural and social factors. Significantly, though, the gendered medical constructions of 'vapors' and hysteria which, as discussed previously, warned that hysteric complaints would progress into madness if left untreated, had the potential to justify the confinement and treatment of 'hysteric' women on smaller grounds than in male cases.[93]

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[88] NRO, BH1170/9; NRO, BH1554.
[89] Battie, *A Treatise on Madness,* 91-92.
[90] Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases,* 95.
[91] NRO, BH10, Minute of 2 September 1771; NRO, BH6, Master's Disbursement 19 January 1771-16 February 1771.
[92] NRO, BH12, Minute of 1 January 1810.
[93] Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy,* 199.

It is particularly important to stress the female-weighted patient population of Bethel Hospital towards the latter end of this period because some confusion has been sown on this point by the only scholarly work to date on Bethel. In his 1994 article, Mark Winston states that in 1806 the board "decided that the Bethel should be enlarged to accommodate officially forty male and twenty female patients."[94] Winston repeats this claim again later in the article.[95] Both of these statements are false. The minute that Winston cites reports the opposite proportion: "It was resolved that the present Establishment be confine'd to about 60 & that for the Accommodation of *40 Women & 20 Men*" (emphasis added). The board even proposes reserving the main building exclusively for female patients and constructing a separate one for the male patients.[96]

Such a mistake is particularly baffling in light of Winston's quantitative assessment of recorded patient discharges conducted in the same article, where he reports that "of [142 patients] repeatedly discharged, 66 per cent were female," a figure which he states "is similar to the proportion of patients discharged just once."[97] He also found that women were more likely to be discharged at the behest of members of their household unit, almost always their husband. This finding indicates that a significant proportion of Bethel's female patients were married; it also suggests that female patients lacking marital ties may have been less able to advocate for their release. Further, Winston's assessment reveals that of the minutes covering the last half of the 18th century, "More than half [of] those [patients] referred to were women, and at some

[94] Winston, "The Bethel at Norwich," 38.
[95] Ibid., 46. He states that ""By 1806 the board perceived there to be a need for beds for twice as many male as female patients." This time Winston cites the "Minute of 19 May 1806"; however, no such minute exists (the minute for May 1806 took place on the 5th of the month), and so it is to be presumed that he is again referring to the Minute of 19 March 1806 that he cites the first time he makes the claim.
[96] NRO, BH12, Minute of 19 March 1806.
[97] Winston, "The Bethel at Norwich," 47.

periods two thirds."[98] Taken all together, the evidence contained in Bethel Hospital's records reveal that women constituted both a majority of the patient population and a major concern of the hospital's administration towards the end of the period under discussion. In light of this fact, the patterns of treatment at Bethel, apparently privileging the treatment of nervous or hysteric conditions, take on a significant new dimension.

Therapeutic bathing was another form of treatment long employed at Bethel Hospital. The records mention a "Washouse" in use at least as early as 1749,[99] while the purchase of two "Dipping Gowns" in 1775 provides the first hint of bathing treatments.[100] A new 'Brick Bath' was ordered in 1785, followed two years later by a 'Wood Bath' explicitly "for the use of the Patients."[101] The Rules and Orders of the Hospital officially adopted in 1797 state that the Master and Matron were to personally administer baths to patients "when ordered by the Physician" in addition to other "medicines," making the therapeutic use of the bath unequivocally clear.[102] Additionally, a 1765 newspaper ad for a private madhouse run by Dr. Beevor while he was a physician to Bethel Hospital stresses both his pedigree at Bethel and the use of "hot and cold baths," suggesting that these were significant to his practice at Bethel as well.[103]

Cold bathing in particular was an exceedingly common treatment for madness throughout the 18th century. Its rationale was often connected to nerves theory; Battie recommended cold bathing to treat anxiety due to its "astringent" virtues which restore the nerves to their "natural

[98] Ibid., 46-47.
[99] NRO, BH9, Minute of 8 May 1749.
[100] NRO, BH6, Master's Disbursement for 29 July-26 August 1775.
[101] NRO, BH11, Minute of 5 September 1785; NRO, BH11, Minute of 2 April 1787.
[102] NRO, BH24. The Master administered treatments to the male patients, while the Matron (often the Master's wife) was to do the same for the female patients.
[103] *The Ipswich Journal,* Saturday 23 November 1765, 3.

firmness."[104] However, it was also often paired with a kind of shock theory. Such theories are seen as early as in the 1720s, where Robinson recommended that if nothing else works in treating madness, "let the Patient be flung from a considerable Height into the water, or let the Water fall from a considerable Height upon his Head."[105] Battie similarly frames "the concussive force of the cold bath" as beneficial.[106] In practice, the forcefulness of this treatment on the body likely served more to ensure the submissiveness of patients by sapping their energy and will to resist. Joseph Mason Cox, for instance, noted the danger of death in administering cold bathing due in part to patients' resistance.[107] As Leonard Smith has noted, in many institutional contexts the cold bath simultaneously fell under therapy, punishment and deterrent through the terror it instilled in patients.[108] It is not clear whether the bathing treatments conducted at Bethel Hospital consisted solely of cold bathing; Dr. Beevor's 1765 ad suggests that he at least made use of both hot and cold baths in his practice at the hospital. In any case, it appears to have been a significant form of treatment at the hospital throughout the majority of the period under discussion.

Another form of treatment which blurred the lines between intentions of healing and the preservation of institutional order was the use of opium and other sedatives. The apothecary's accounts for 1810 at Bethel Hospital record the administering of a 'tincture of opium' (i.e. laudanum) to a patient, while 'Anodine' (i.e. a painkiller) is also mentioned in the 1795-96 accounts.[109] An 1811 medical guide lists among the uses of opium "allaying inordinate action,

[104] Battie, *A Treatise on Madness,* 91-92.
[105] Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy,* 67-68, 398.
[106] Battie, *A Treatise on Madness,* 92.
[107] Cox, *Practical Observations on Insanity,* 123-124.
[108] Smith, *'Cure, Comfort and Safe Custody,'* 203.
[109] NRO, BH1178/3; NRO, BH1170/9.

and diminishing morbid irritability."[110] The potential application of these functions are clear in a lunatic hospital reliant upon maintaining conditions of confinement and quelling violence and resistance to its authority among the patient population. William Battie recommends anodynes as "absolutely necessary in every case of consequential anxiety," while Monro recommends opium to treat mania.[111] Others, however, had dismissed the use of opium as ineffectual for treating madness by the 1800s,[112] and so the fact that it was only sporadically employed at Bethel Hospital by this later period is unsurprising.

Some writers instead recommended Nitre as a sedative.[113] Nitre is a particularly interesting case in the treatments employed at Bethel. It was not included in apothecaries' accounts, but Nitre was regularly purchased by the hospital's Master beginning in the mid-1770s.[114] Even more intriguingly, in 1783 the board explicitly ordered Dr. Manning "to prescribe the Nitre for the Patients that is provided by this House."[115] There are no similar incidences of specific medical treatments being mandated at the level of the hospital's board of trustees throughout this period. In light of the wider use of nitre as a sedative, it is not unreasonable to suggest that the hospital administration may have provided and mandated the administering of nitre in this instance as a means to ease the management of the more unruly patients within the institution. It appears to be another instance of medical treatment intermingling with staff's goals

[110] Richard Reece, *The Medical Guide,* 8th edition. (London: Longman, Hurst, Rees, Orme, and Browne, 1811), 41, 43.
[111] Battie, *A Treatise on Madness,* 91-92; Monro, *Remarks on Dr. Battie's Treatise on Madness,* 44.
[112] e.g. Haslam, *Observations on Insanity,* 147; Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases,* 96.
[113] Rowley, *A Treatise on Female, Nervous, Hysterical, Hypochondriacal, Bilious, Convulsive Diseases,* 299-300; Thomas Arnold also recommends nitre as a component of treatments for 'phrenetic symptoms' of hysteria: Arnold, *Observations on the Nature, Kinds, Causes, and Prevention of Insanity, Lunacy, or Madness volume I,* 22.
[114] NRO, BH6.
[115] BH11, Minute of 7 April 1783.

of maintaining order in the institutional context. Patients physically depleted from purges, cold baths or sedatives were overall less likely to physically resist their confinement, and thus more likely to evince behaviour taken by the physicians to be indicative of cure or, at the least, a lack of danger posed by the patient to the public. Discharge decisions contain hints of these judgements; certain patients were described upon their discharge in terms such as "not mischievous," "being perfectly inoffensive," and "sedate."[116]

1.5 The Possibilities of Practice: Curative Isolation versus Moral Treatment

Little evidence exists of any systematic practices of 'moral treatment' employed by Bethel Hospital's practitioners or administrators responding to the advances of the Tukes and others discussed above. There were, however, some initiatives by individual administrators potentially in line with practices that would later be termed moral treatment that were quickly overridden by others involved with the hospital's management. In general, we find more indications of the opposite of moral treatment's precepts found in a principle of curative isolation restricting patients' social contact with others. Eighteenth-century writers on madness agreed that the isolation of the patient was imperative to treatment, which served as a particular justification for institutional confinement. Writing in 1758, Battie advocated isolation in terms of reorienting sensory stimuli, positing that "delusive Sensation […] requires the patient's being removed from all objects that […] excite too lively a perception of things," before asserting that visits by friends "ought strictly to be forbidden."[117] Monro similarly emphasizes that patients "should at

[116] Quotes are, respectively, the discharge of patient Harrington Willis: NRO, BH12, Minute of 5 September 1791; Discharge of patient Stephen Sparks: NRO, BH12, Minute of 1 June 1801; Discharge of patient Elizabeth Doughton: NRO, BH12, Minute of 5 January 1795.
[117] Battie, *A Treatise on Madness,* 68-69.

first converse with few" and that visitations can prove "highly detrimental."[118] As Foucault noted, such judgements tended to indiscriminately position patients' families as a catalyst of madness, whether justified or not.[119]

In line with these developments in prescriptive literature, in 1758 Bethel Hospital's board ordered "that for the future no Lunatics in this Hospital shall have private Conversation with their Husbands or Wives who shall come to see them" except "in the presence of the Master or Mistress."[120] This policy constituted a significant expansion of the hospital administrators' social control over patients. In fact, they considered any kind of contact with the outside world a cause for concern. In 1769 the board discussed "how far needful to prevent the Communication of the com[m]on people with the Lunaticks at the Front Iron Gate."[121] Nonetheless passersby continued to be able to talk to patients from behind this gate and vice versa. The novelist Amelia Opie describes how in Norwich during the 1770s, she

> sometimes passed the city asylum for lunatics […] and we used to stop before the iron gates, and see the inmates very often in the windows, who would occasionally ask us to throw halfpence over the wall to buy snuff.[122]

The Rules and Orders of the hospital adopted in 1797 further decreed "That no Lunatick be visited by their Friends oftener than twice in a Month."[123] These recurring concerns of the board were particularly ironic in light of their policy allowing members of the public to freely visit the interior and view the hospital's patients on a daily basis, which continued at least as late as 1794.[124] Administrators appeared to consider viewing the hospital's mad patients from a safe

[118] Monro, *Remarks on Dr. Battie's Treatise on Madness,* 38-39.
[119] Foucault, *Psychiatric Power*, 98-99.
[120] NRO, BH10, Minute of 18 September 1758.
[121] NRO, BH10, Minute of 7 August 1769.
[122] Amelia Opie, *Memorials of the Life of Amelia Opie*, 2nd ed., ed. Cecilia Lucy Brightwell (Norwich: Fletcher and Alexander, 1854), 14.
[123] NRO, BH24.
[124] NRO, BH12, Minute of 4 August 1794.

distance acceptable, but any direct social engagement with them threatened to subvert the therapeutic authority of the hospital's practitioners in their attempts to regulate a curative social environment.

Prescriptions of isolation continued into the 1790s, extending to policies of solitary confinement. John Haslam asserted in 1798 that "in the most violent state of the disease, the patient should be kept alone in a dark and quiet room, so that he may not be affected by the stimuli," a practice that contained shades of Battie's focus on preventing sensory stimuli.[125] Even the Tukes had a similar room to confine violent or insubordinate patients at the York Retreat.[126] This context may explain a mysterious reference in Bethel records to "the room call'd the dark room," which was converted into a regular cell in 1750.[127] Solitary confinement was also enforced at Bethel in a cellar reserved for "ye worst of the Lunicates [sic]" from 1749 on,[128] but it is not clear whether this room had any therapeutic rationale beyond simply segregating the most volatile patients from the general population and punishing acts of resistance to the hospital's authority. It may also have acted as a deterrent through the mere threat of confinement within it (as in the case of the cold bath).[129] Once again in the 18th-century institutional environment, distinctions between the medical treatment of individuals and the general management of order remained firmly intertwined.

In the later part of the century, certain hints of potential practices of 'moral treatment' at Bethel Hospital exist, but tellingly, these hints also reveal the subsequent rejection of such practices. It is instructive to compare these practices to those of the Tukes at the York Retreat,

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[125] Haslam, *Observations on Insanity,* 126.
[126] Tuke, *Description of The Retreat,* 98.
[127] NRO, BH9, Minute of 28 May 1750.
[128] NRO, BH9, Minute of 8 May 1749.
[129] Smith, *'Cure, Comfort, and Safe Custody,'* 203.

who formed the most influential precepts of 'moral treatment' that were brought to the new County Asylums in the 1810s and influenced countless other institutions.[130] One of the notable features of the Tukes' Retreat was the fostering of a comfortable environment, including outdoor courtyards where patients could gain benefits of air and exercise while viewing the natural surroundings of the countryside.[131] The general belief in the healthful effects of open air was also held by at least some of Bethel's physicians. Dr. Henry Reeve (at Bethel c. 1808-1815) published an article in 1808 on Cretinism (i.e. Congenital iodine deficiency syndrome), speculating that it "may be prevented by removing children from the confined and dirty places where it prevails, and nursing and educating them in the higher parts of the mountains."[132]

Bethel Hospital too had outdoor courtyards for its patients to walk around in, but in the urban context of Norwich, these spaces were by necessity much smaller and more tightly controlled than at the York Retreat. In 1797 the board ordered "that the Womens yard be restored to its former state Namely Grass plot and Gravel walk round without Shrubs or Flowers." By this time the Women's yard would have been presided over by the Matron (who was typically the Master's wife). Even more intriguingly, the board simultaneously ordered "No Pigeons or Poultry of any description to be kept by the Master within any part of the Hospital Premises."[133] A significant feature of the York Retreat was its therapeutic use of animals.[134] The keeping of animals in courtyard areas is a striking similarity between Bethel Hospital and the York Retreat

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[130] Ibid., 212-213.
[131] Digby, *Madness, Morality, and Medicine,* 38.
[132] Henry Reeve, "Some Account of Cretinism," *Philosophical Transactions of the Royal Society of London* Vol. 98 (1808), 118.
[133] NRO, BH12, Minute of 6 November 1797.
[134] Samuel Tuke described in 1813 that "The superintendent has also endeavoured to furnish a source of amusement […] by supplying each of the courts with a number of animals; such as rabbits, sea-gulls, hawks, and poultry. These creatures are generally very familiar with the patients." Tuke, *Description of The Retreat,* 96.

in roughly the same time period (the Retreat had only opened in 1796), but in Bethel's case the practice was apparently short-lived. It seems to have derived from the initiative of the hospital's Master but was deemed improper by the institution's board. The prohibition is significant in light of the institution's principles of curative isolation from all stimuli. In stark contrast to the environments of comfort and amusement cultivated at the Retreat, at Bethel Hospital not only animals, but even the mere existence of shrubs and flowers were potentially seen as posing excessive sensory stimulation to the patients. If these motivations indeed undergirded the board's 1797 order to any serious extent, they only further reflected the hospital's preference for isolating its patients from all stimuli in a kind of enforced boredom.

Another small yet surprising similarity between the two institutions is seen in the augmentation of door locks. At the York Retreat the Tukes decided to encase the locks to patients' cells in leather in order to prevent exposing patients to the harsh sound of them being crashed shut at night.[135] In 1762, the Master of Bethel Hospital paid for eight locks to be covered with leather "By order of the Physician."[136] The explicit role of the hospital's physician in this decision significantly suggests its treatment-oriented motivations, a full 34 years before the Retreat opened its doors. If the goal, following the recommendations of contemporary prescriptive literature, was to prevent patients from being exposed to excessive sensory stimuli in order to effect the cure of their madness, then the management of sound formed a significant part of that therapeutic milieu for Bethel's physicians.[137] It is significant that this practice served to slightly mollify carceral environments towards a therapeutic end in both institutions. The respective adoptions of the practice recognized that the conditions of confinement, as they were,

[135] Digby, *Madness, Morality, and Medicine,* 39.
[136] NRO, BH5, Master's Disbursement for 5 December 1761-2 January 1762.
[137] Fennelly, "Out of Sound, Out of Mind: Noise Control in Early Nineteenth-Century Lunatic Asylums in England and Ireland," 422.

contained harsh elements that might in fact prove detrimental to the treatment and cure of insanity, which spurred the development of more sophisticated therapeutic technologies.

It is also possible that a form of moral treatment was explicitly encouraged by at least one of the trustees of Bethel Hospital. The Rules and Orders of Bethel, adopted by the hospital board in 1797, contain one clause that stands out from all the rest:

> That the Master and Matron be inform'd and thereby impress'd with a sense of the duty and humanity they owe to the Patients of the House and that in obstinate resistances of the Patients to be governed no blows or correction with any weapon be used but the most gentle and humane means observed and followed to controul the obstinate paroxysms of the Patients.[138]

The oversight of the Master's methods of management by the hospital board of trustees had some precedent. The hospital's first Master, Robert Waller, was removed by the board in 1725 partly on the grounds that he "corrected some & managed others of ye said lunaticks in an undue manner."[139] However, the direct appeal to the humanity of the patients seen here is new, as well as the call for "the most gentle and humane means" of management. This language reflects the contemporary emergence of moral treatment in the 1790s as an at first controversial, but increasingly acceptable implementation of Lockean ideas among therapeutic innovations at the Quaker Retreat and elsewhere.[140] If the clause had a strong correlation to the practices within the hospital, it could be argued to align with this early ethos of moral treatment. However, a bold black line runs downward striking through the entire clause.

The simultaneous inclusion and negation of these recommendations in the Rules and Orders raises some questions. Who pushed for their inclusion? It was likely not a majority of the seven trustees; the very next clause, after this one calling for the humanity owed to the patients,

[138] NRO, BH24.
[139] NRO, BH9, Minute of 2 June 1725.
[140] Laffey, "Two Registers of Madness in Enlightenment Britain part 2," 74.

calls for all tools to be kept from the reach of "the deranged patients," a striking shift in tone.[141] It is possible that it was formulated in response to specific punitive practices by a Master or Matron that some board members disapproved of as overly violent even for the institutional context (this is particularly hinted at by the specific reference to "blows or correction with any weapon"). One potential explanation for the line striking out the clause is that perhaps its non-coercive recommendations were initially considered, but ultimately deemed ineffective in quelling patient resistance and maintaining the conditions of confinement within the hospital.

In any case, instances such as this present a more nuanced picture of Bethel Hospital's management than typically comes through in the surviving sources. It significantly shows that the practices of treatment and management carried out on the hospital's patients were never a foregone conclusion. They were up for debate, and could be influenced not only by trends in contemporary literature, but also by the initiatives of individual staff (which could in turn be overridden by administrators and trustees). The few dissenting voices against the largely conventional medical regimes of treatment and management carried out at the hospital from 1724 to 1815 complicate the picture of its continuity, while simultaneously demonstrating the tenacious power of institutional inertia within board-governed lunatic hospitals during the long eighteenth century.

[141] NRO, BH24.

2

Patient Mobilities in the Architecture of Confinement

> […] *such lunatic persons as shall from time to time be put as aforesaid into the said House shall be kept close and not suffered to wander abroad during their disorder"*[1]
>
> — Mary Chapman, 1717

> […] *never can I forget the terror and the trembling which seized my whole frame, when, as I stood listening for my mad friend at the door, I heard the clanking of his chain!*[2]
>
> — Amelia Opie

From modest beginnings, the structure of Bethel Hospital underwent major physical additions, renovations and reinforcements throughout the first century of its operation. The Hospital's Board of Governors enacted these alterations not only to accommodate an ever-expanding patient population, but also in order to exert an increasingly sophisticated control over the mobility of this population within the confines of the institution. This control was one of the essential functions of 18th-century lunatic hospitals and their later iterations, asylums.[3] The curtailment of patient mobility was one of Bethel Hospital's original mandates (as Chapman outlined in her will), and it was manifested through the enforcement of increasingly restrictive policies by hospital administrators, the use of various mechanical restraints, and perhaps most fundamentally the elaboration of architectural features such as reinforced walls, iron grates over doors, and iron bars in windows. This combination of strategies worked collectively to circumscribe the daily lives of patients to specifically designated spaces within the building and

[1] NRO, BH21, 14-16.
[2] Opie, *Memorials of the Life of Amelia Opie,* 14.
[3] Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007), 15.

on the grounds. Over time, the board members and physicians instituted the separation of spaces grouping patients by gender, by the presence of physical illness, and by the severity of their resistance to confinement. Consequently, an individual patient's spatial experiences of the hospital could differ from those of others based on an entire matrix of considerations funneling them to one set of internal spaces or another.

It is important to stress, however, that in spite of this general restriction of mobility, Bethel Hospital's patients did find various ways to resist conditions of confinement, extend their mobility and exert some manner of agency in their daily navigation of the Hospital's grounds. It would be a mistake to view the 18th-century lunatic hospital as enacting a python-esque total suffocation of its patients' mobility in the form of shackles or the straitjacket. As we will see, the strategies to subvert architectural restrictions, mechanical restraints and administrative severity were varied.[4] Formless and ill-defined, the spectre of madness evinced no boundaries, and in attempting its restriction the hospital's staff lived in constant fear of its supposed dormant transgressive force. This fear underlaid many of the restrictive policies of the hospital, but for hospital patients the power to inspire such fear through transgression of these policies offered one way to resist their enforced passivity. Aside from more dramatic examples of violent resistance or escapes, patients could also assert their autonomy in smaller and more benign ways, with some for instance attaining greater mobility by endearing themselves to the hospital's authority. The spatial strategies and mobilities available to Bethel Hospital's patients underscore

[4] The potential for studying human geographical mobilities within carceral institutions designed for immobility is stressed by Philo, "One Must Eliminate the Effects of … Diffuse Circulation [and] their Unstable and Dangerous Coagulation': Foucault and Beyond the Stopping of Mobilities," 495. Michel De Certeau also emphasizes the need to move beyond narratives of repression as a response to Foucault's elaboration of institutional 'disciplinary power,' proposing a study of 'antidiscipline' or the resistant "ways of operating" by which "users reappropriate the space organized by techniques of sociocultural production." Michel De Certeau, *The Practice of Everyday Life,* trans. Steven Rendall (Berkeley: University of California Press, 1984), xiv.

the limitations of the institution's ability to regulate their daily lives towards therapeutic and managerial ends.

2.1 Understanding the Geography and Architecture of Bethel Hospital

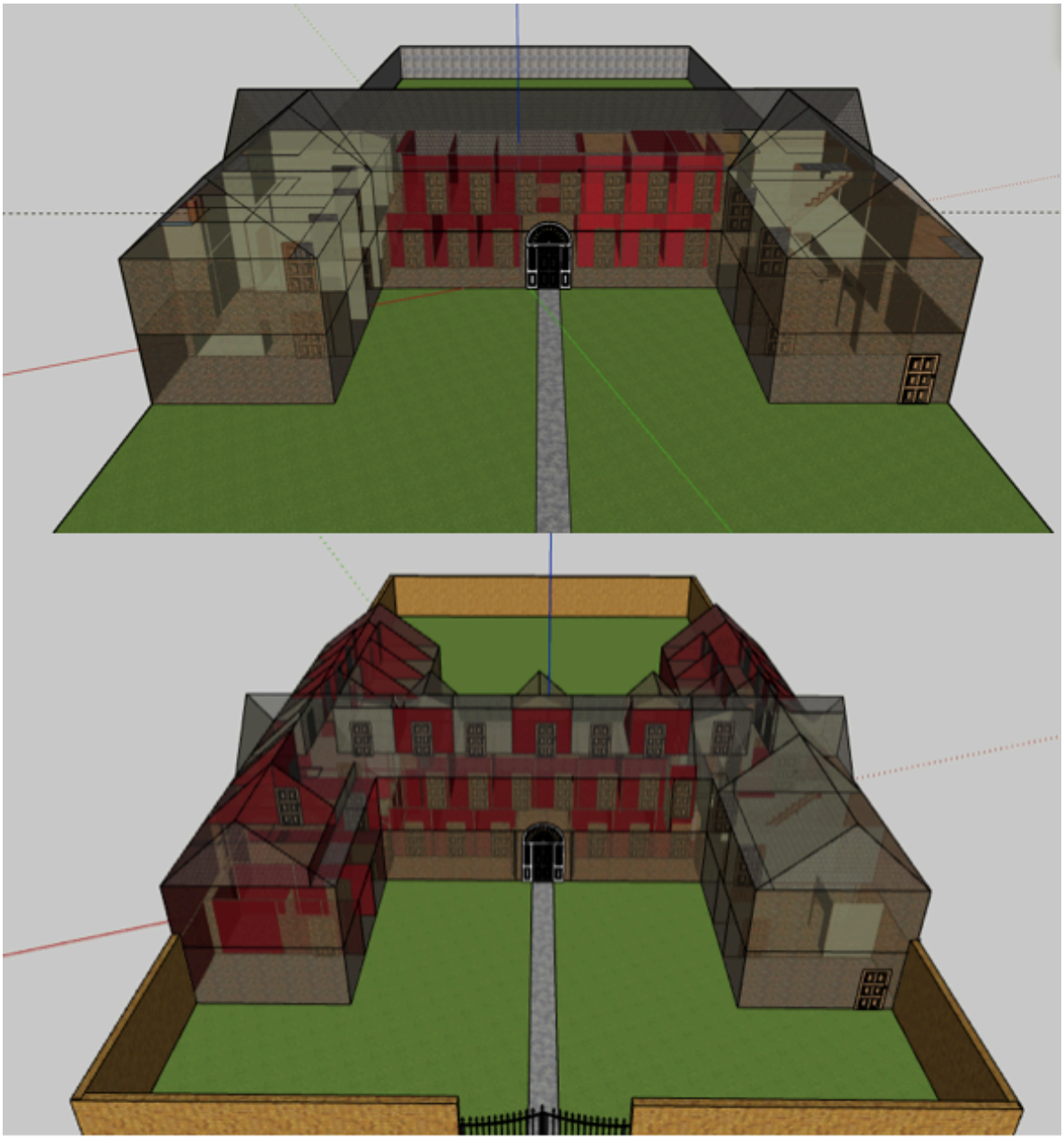

Figure 2.1 - 3D models of Bethel Hospital's interior architecture over time, viewed from the north side - top c. 1727, bottom c. ~1766 (Patient cells/likely habitation areas tinted red)[5]

[5] The green line indicates the latitudinal axis, and the red line the longitudinal axis. These models were created with the software Google Sketchup (https://www.sketchup.com/), based on information combined

The earliest surviving contemporary source for the construction of Bethel Hospital is a 1712 building agreement detailing the specifications of a house to be built in the parish of St. Peter Mancroft in the city center of Norwich.[6] Notably, Norwich was one of the first major cities in Britain outside of London, having reached a population of about 29,000 by the mid-1690s.[7] The institution's urban location was similar to that of other roughly contemporary lunatic hospitals, such as Bethlem Hospital and St. Luke's Hospital (est. 1751), both located in London. As historians such as Leonard Smith have outlined, public asylums in Britain remained essentially "urban phenomena" until as late as the 1820s, as publications on institutions in rural locations encouraged a gradual enshrinement of the country locale as the ideal environment for treating madness.[8]

The description of the building as a 'house' in the building agreement is also unsurprising. Traditionally lunacy was treated in the home; some early founders of institutions for the mad thus set out to recreate domestic environs to ease the transition to institutional care.[9] Domestic features are prominent in the building's architecture. Bethel was initially built in a U or 'half-H' hall-and-crosswings shape likely modelled after 17th-century British large houses,

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principally from the following sources: late 19th-century maps of Bethel Hospital held at the Norfolk Record Office (NRO, BR 35/2/94/3/1-21); the maps and architectural survey contained in Rowenna Wood, Purcell et. al, *Bethel Hospital, Norwich Conservation Management Plan* no. 3 (September 2016); specifications of the 1712 Building Agreement, reproduced in Bateman and Walter Rye, *The History of the Bethel Hospital at Norwich*, 164-175; and the Bethel Hospital Board of Governors' Minute Books (BH9, BH10, BH11, and BH12 at the NRO). These models are not intended to be definitive representations of the building's internal layout over time, but rather an illustrative interpretation based upon the very limited surviving evidence.

[6] This document is fully transcribed in Frederic Bateman and Walter Rye, *The History of the Bethel Hospital at Norwich* (Norwich: Gibbs and Waller, 1906), 164-175.

[7] Armstrong, "Population: 1700-1950," in *Norwich Since 1550,* 244.

[8] Leonard Smith, "The Architecture of Confinement: Urban Public Asylums in England, 1750-1820," in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context,* eds. Leslie Topp et. al (New York: Routledge, 2007), 41; Chris Philo, *A Geographical History of Institutional Provision for the Insane From Medieval Times to the 1860s in England and Wales*, 441.

[9] Stevenson, *Medicine and Magnificence*, 8.

where wings project outward from a rectangular body to frame a courtyard in front.[10] The building's basis in domestic architectural forms was also reflected by its internal decor; the agreement specified to "adorne all things in the roomes […] in the manner as houses of about twelve pounds a yeare are usually finished and adorned."[11] Moreover, following its construction Mary Chapman literally made the building her home until her death in 1724.[12]

At the same time, however, the building's function as a center of confinement was indicated by additional carceral elements in its construction. The 1712 agreement orders iron grates to be placed upon the inside of room doors, iron bars on all windows in cells, and additionally mentions a "fence wall which is now built" in the yard of the property.[13] Here we see the physical manifestations of Chapman's directive that inmates "shall be kept close and not suffered to wander abroad during their disorder."[14] These architectural elements of confinement were reflective of lunatic hospitals' stated role to protect society from the danger of 'lunatics' and were likely influenced by the designs of contemporary prisons.[15] The specifications indicate a total of thirteen rooms appearing to function as cells on the ground and first floors of the central block in the original building (see the red tinted parts of the 3D model in Figure 2.3).[16] If

[10] Ibid., 35; Christopher Hussey, *English Country Houses: Early Georgian 1715-1760* (London: Country Life Limited, 1955), 13.
[11] Bateman and Rye, *History of the Bethel Hospital at Norwich*, 173.
[12] A 1743 inventory of the building indicated that Chapman's bedroom and belongings in the hospital remained undisturbed in the years following her death: NRO, BH16, "An Inventory of the Goods at Bethel taken January 10: 1743."
[13] Bateman and Rye, 169, 171, 175.
[14] NRO, BH21, 14-16.
[15] Smith, "The Architecture of Confinement," 43.
[16] Bateman and Rye, 169; Wood et. al, *Bethel Hospital, Norwich Conservation Management Plan,* 32. The agreement describes six cells on the ground floor central block, separated by a central corridor running from the front door to the back door of the block, and seven rooms above these. Four of the first-floor cells appear to have survived into the late 19th century and are thus depicted on contemporary floor plans, while the ground floor cells and three of the first-floor cells had evidently been demolished/repartitioned by this point: NRO, BR 35/2/94/3/1-21. These surviving cells suggest that the

these rooms were fitted to house two patients each, then this would suggest that the building was originally intended to house a maximum of twenty-six patients. This rough estimate is borne out by the earliest surviving patient population figures, which record a total of twenty-seven 'lunatics' in the house in the year 1730.[17]

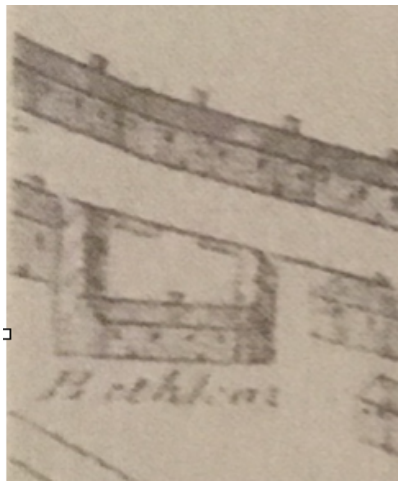

Figure 2.2- Depiction of Bethel Hospital in Corbridge's map of Norwich, c. 1727[18]

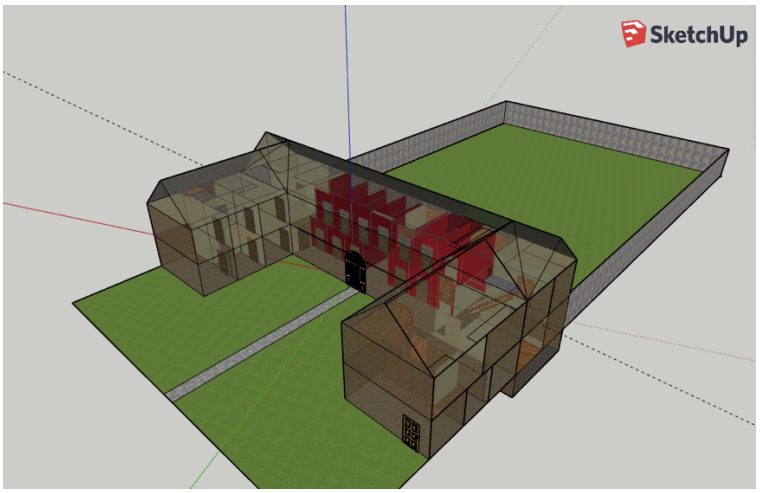

Figure 2.3- 3D model of building c. 1727, viewed from Northwest (Patient cells tinted red; green line represents latitude, red line represents longitude)

Not much can be gleaned about the hospital's first eleven years of operation following its construction, during which Mary Chapman was still alive and likely residing in the building for some period of time.[19] In the decades following Chapman's 1724 death, however, upon which the administration of the hospital fell to a public board of trustees (comprised chiefly of

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cells on the first floor as well as the ground floor were accessed by corridors running lengthwise down the central block.

[17] NRO, BH5, Master's Disbursements for October 1730.

[18] In Christopher Barringer, "The Changing Face of Norwich," in *Norwich Since 1550,* eds. Carole Rawcliffe and Richard Wilson (London: Hambledon and London, 2004), 14. The conflation of Bethel with the much more infamous Bethlem Hospital in London appears to have been a fairly common misconception in the period under discussion.

[19] Philo, *A Geographical History of Institutional Provision for the Insane From Medieval Times to the 1860s in England and Wales,* 446.

prominent local political figures),[20] demand for the hospital's service and an ever-rising patient population obligated physical expansions and re-appropriations of the building's space. As early as 1727 the board ordered that "there be six wards more made ready as soon as conveniently may be."[21] As mentioned, by this time the hospital was already reaching or slightly over its initial maximum capacity. The patient population would only continue to grow in the years to come, far beyond any scale the original building could possibly contain.

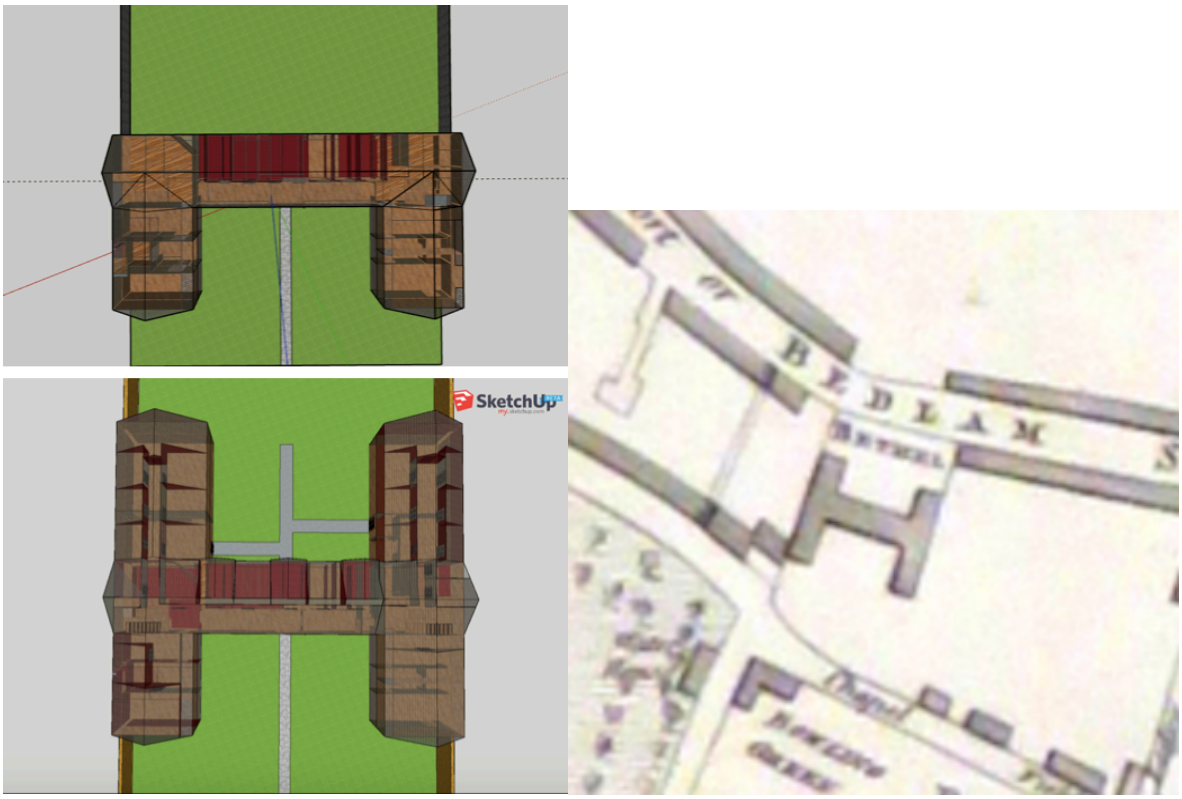

Figure 2.4 (left) - Overhead Views of Bethel 3D Models, showing expansion (top c. 1727; bottom after 1753-6 addition of southern wings). Bottom paths facing northward to 'Bedlam street.'
Figure 2.5 (right) - Depiction of Bethel Hospital's H-shape in Samuel King's 1766 map of Norwich[22]

[20] Winston, "The Bethel at Norwich," 33. As Winston notes, many of the board members were members of the Whig party in Norwich.
[21] NRO, BH9, Minute of 21 April 1727. The board ordered that one more ward be made up in the east wing of the hospital a few months later, while also ordering the construction of a staircase in the east wing to increase the accessibility of the upper floors: NRO, BH9, Minute of 26 June 1727.
[22] Samuel King, "The City and County of Norwich" (1766), via https://colonelunthanksnorwichdotcom.files.wordpress.com/2018/08/samuel-

Thus in 1753 work began on two new southern wings to the hospital. By approximately 1756, with the new additions the building had assumed an H-shape.[23] The building's new shape was similar to some contemporary hospitals, such as the Edinburgh Infirmary (est. 1738).[24] As the 3D models in Figures 2.1 and 2.4 suggest, the addition of these southern wings constituted a dramatic expansion of the hospital building's physical facilities. These models were created with the software Google Sketchup for the purposes of illustrating the scale of the building's expansion generally. Spaces in the building that patients likely inhabited (i.e. cells or common living spaces) are tinted red in these models, based on the evidence of the original building specifications combined with later maps. However, they are not intended to reflect aspects of what the interior spaces of the hospital looked like in any concrete sense. It must also be noted that the size of the southern wings depicted in the models is based primarily on surviving maps of the hospital dating later from the 19th century, in conjunction with Rowell Wood et. al's conservation report, and so should not be taken as definitive. A more contemporary map dating from 1766 (Figure 2.5) is provided alongside Figure 2.4 for purposes of comparison.

Most of this new interior space was apparently reserved to house a greater number of patients; a 1756 inventory of the hospital indicates a total of 53 cells. The new wings also included a new boardroom, new lodgings for the Master, a Washhouse, and sick-rooms for male and female patients.[25] These new accommodations allowed a dramatic spike in patient numbers.

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kingsmapinset.jpg?w=468&h=406. Accessed August 20, 2019. The building is depicted in the opposite latitudinal orientation to that of the 3D models in Figure 2.4, with the north wings facing 'Bedlam Street.'

[23] NRO, BH9, Minute of 19 November 1753; Wood et. al, *Bethel Hospital, Norwich Conservation Management Plan,* 55; the building's new H-shape is first seen depicted in Samuel King's 1766 map of Norwich (see Figure 2.5): Barringer, "The Changing Face of Norwich," 18.

[24] Stevenson, 141.

[25] NRO, BH16, "An Inventory of Goods at Bethel taken the 30th day of July 1756."

By 1759, the patient population had peaked at 54, compared to around 20-30 through most of the 1730s and 40s (see Figure 2.6).

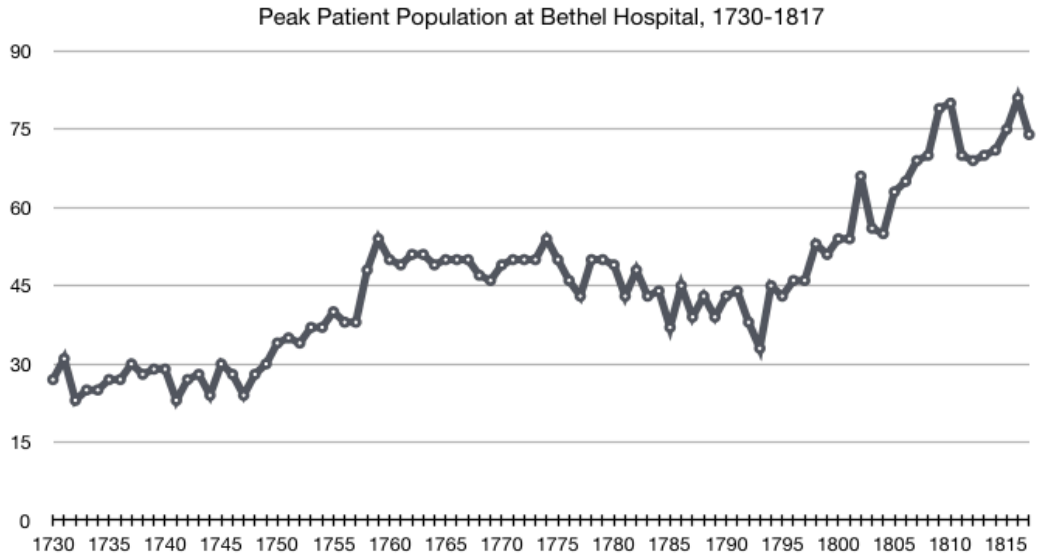

Figure 2.6 - Peak Patient Population Over Time[26]

Bethel Hospital held a prominent geographical place in the local community over time. The institution's visibility was a major priority for Mary Chapman, offering a means for her to promote a self-image of piety and charity.[27] She willed that the word Bethel (a Biblical place-name meaning "House of God" and connoting a place of sanctuary), along with a bible verse concerning charity, "be set in Capitall letters on ye front of ye s[aid] house Deeply engraven with large Letters […] & made visible to all Spectators."[28] Such a facade would instruct the observer

[26] The term "peak population" here refers to the highest number of patients recorded to be residing in the hospital at any one time during a specific year. This data was collected from the Hospital Master's Disbursements books: NRO, BH5, BH6, and BH7.
[27] James Moran and Leslie Topp, "Introduction: Interpreting Psychiatric Spaces," in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context,* eds. Leslie Topp, James E. Moran and Jonathan Andrews ((New York: Routledge, 2007), 1.
[28] NRO, NCC Lawrence 216; Nadav Na'aman, "Beth-aven, Bethel and Early Israelite Sanctuaries," Zeitschrift des Deutschen Palästina-Vereins 103 (1987), 17.

to interpret the building in terms of its charitable function, both publicizing Chapman's legacy and encouraging further donations to the hospital to ensure the institution's survival.[29]

It is unknown to what extent these specific wishes were carried out after Chapman's death. Perhaps they were not fully implemented due to increasing concerns over apparent vanity and over-luxury in hospitals' displays in the 18th century.[30] Regardless, however, it is important to note that hospital buildings in themselves acted as notable visual symbols in the urban landscape.[31]

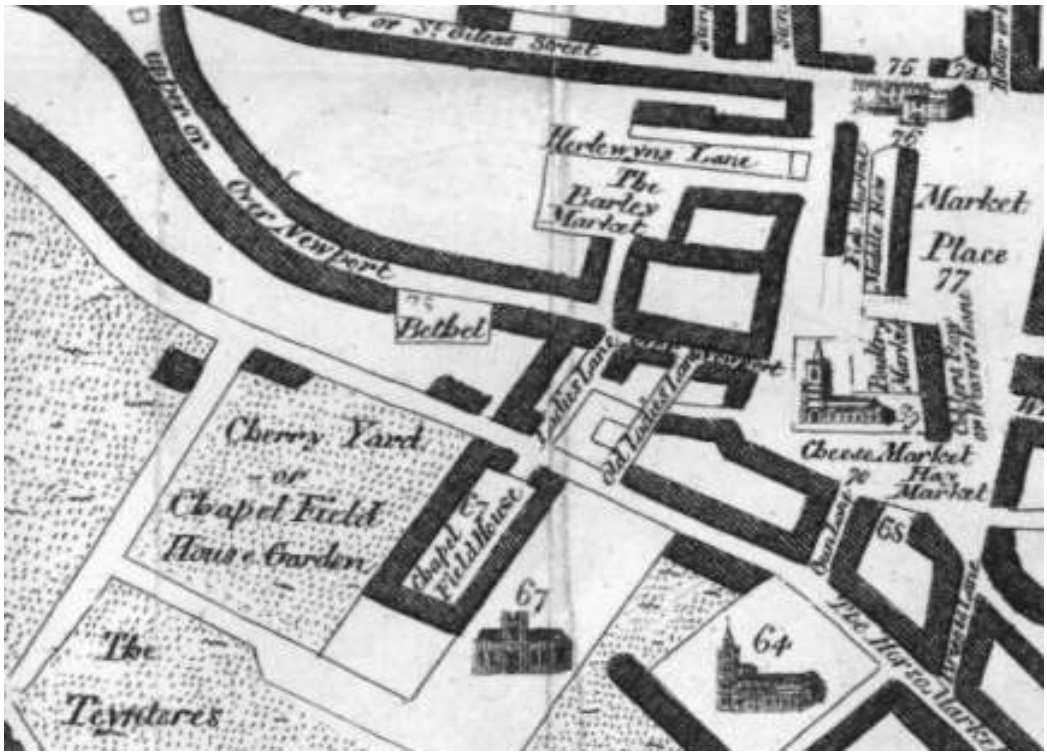

Figure 2.7 – Bethel Hospital and Local Surroundings as depicted in Blomefield's map of Norwich c. 1741[32]

[29] Dana Arnold, *The Spaces of the Hospital: Spatiality and Urban Change in London 1680-1820* (New York: Routledge, 2013), 46; Christine Stevenson, "Robert Hooke's Bethlem," *Journal of the Society of Architectural Historians* vol. 55, no. 3 (September 1996), 255.
[30] Stevenson, *Medicine and Magnificence,* 20-21.
[31] Arnold, *The Spaces of the Hospital,* 7.
[32] Francis Blomefield, "Plan of the City of Norwich." *George Plunkett's Photographs*: http://www.georgeplunkett.co.uk/Website/Maps/1741%20Blomefield.jpg

Located in the richest parish in Norwich, a short distance from both the St. Peter Mancroft church and the open markets of the city (see Figure 2.7), Bethel Hospital's visibility indeed came to lend it a certain reputation, but it may not have been the kind that Chapman intended. A policy allowing members of the public to freely visit the hospital grounds, similar to that infamously instituted in Bethlem Hospital in London during the same period, quickly became exceedingly popular. The board reprimanded the Hospital's Master, Robert Waller, in 1725 after he "at several times lett great num[bers] of people into the House to the no small disturbance of the Lunaticks."[33] The board then limited the number of persons allowed in the hospital at a single time to "ten or twelve," but the general policy continued at least as late as 1794.[34] As early as 1766 the street the hospital adjoined was dubbed "Bedlam Street."[35] The public focused not on the charity of Mary Chapman, nor any supposed virtue of the institution's function, but rather on the captivating forms of madness and anarchy the Hospital professed to contain from wider society while also displaying them to that same society.

[33] NRO, BH16, Minute of 28 June 1725; Stevenson, "Robert Hooke's Bethlem," 254.
[34] NRO, BH16, Minute of 28 June 1725; The latest extant reference to "the Liberty usually given to the Publick to view the Premises" is made in NRO, BH12, Minute of 4 August 1794.
[35] Curtis H. Dittbrenner, "The Poor Law and the Problem of Poverty in Norwich and Norfolk, 1660-1760," PhD Diss. (University of Wisconsin, 1973), 14; Barringer, "The Changing Face of Norwich," 18.

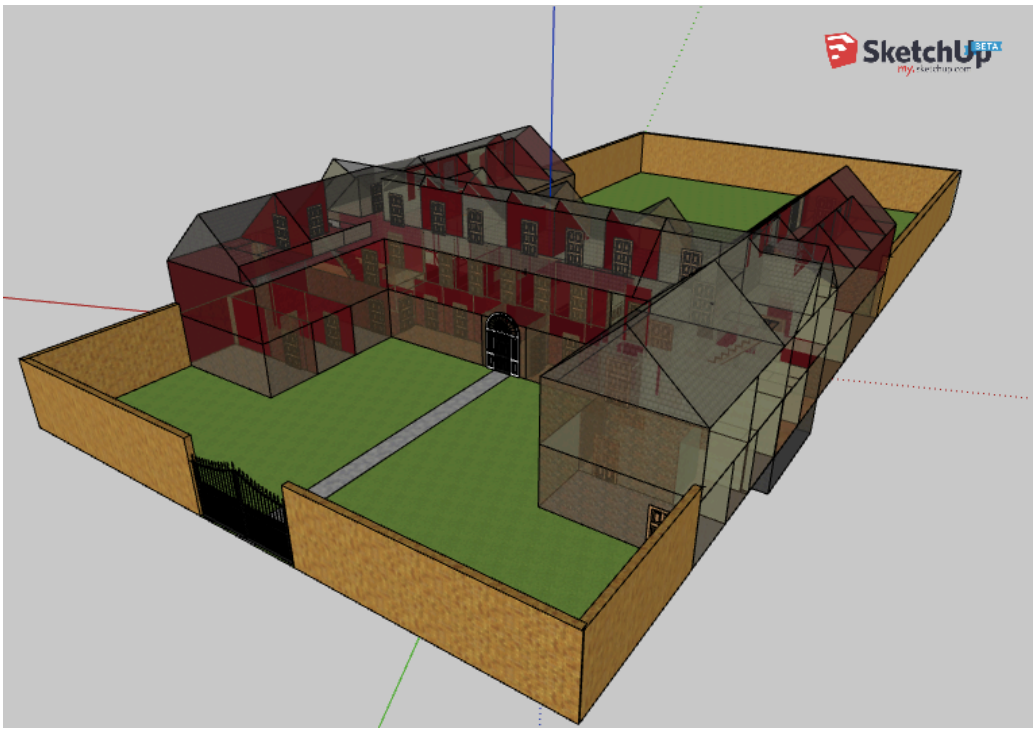

Figure 2.8 - Model of Bethel Hospital interior and grounds, view from Northwest c. ~1766

2.2 "For the Disorderly Lunaticks": Tactics of Restraint

Bethel Hospital's board of trustees, Master, Matron, and attendants worked in concert to ensure that patients' movements and actions did not transgress the boundaries they deemed proper. In practice, these boundaries were principally determined by the board-appointed Master and the Matron. Perhaps the most fundamental of these regulations was that barring patients from leaving the hospital grounds. This basic restriction of mobility was common to hospitals, being necessary to carry out any form of medical treatment.[36] But for the treatment of individuals deemed mad, prone to resist, and often posited to pose a danger to all around them, the policies of confinement were enacted with extra rigor. The architectural features of confinement

[36] The Norfolk and Norwich Hospital, for example, ordered soon after its 1771 founding that patients were to leave the hospital "on no pretence whatsoever": Peter Eade, *The Norfolk and Norwich Hospital, 1770-1900* (London: Jarrold and Sons, 1900), 46.

contained in the original iteration of the hospital building have been outlined above; in subsequent years the board regularly undertook fresh initiatives to further reinforce the security of the grounds.

The changing barriers on the hospital grounds illustrate this general trend. As discussed, originally the grounds of the hospital were framed by a "fence wall;" the exact meaning of this term is unclear, but may have simply referred to a wooden fence functioning as a barrier to keep individuals in and out of the property.[37] In 1735 an iron gate was installed in the front yard, allowing greater control over the primary access point to the property.[38] A few years later this was supplemented by the 1741 construction of "Bethel Wall," presumably a wall enclosing the majority of the property.[39] Bethel Hospital's enclosure then became even more complete in 1747 with the construction of a 14-inch-thick brick wall extending from the back side of the building to an existing wall at the back of the yard.[40] The back wall was later taken down and rebuilt in 1800.[41] Presumably this was a measure to increase security; in 1795 several repairs were made to "breaks" in walls on the hospital grounds, including the wall in the "Man's Yard."[42] Notably, these repairs potentially hint at inmates' attempts to break through the different physical barriers that the hospital imposed upon them.

[37] Bateman and Rye, 175.
[38] NRO, BH9, Minute of 11 August 1735. Board minutes indicate that there was previously a "front gate" as early as 1725: NRO, BH16, Minute of 28 June 1725. A lock was purchased for the gate in 1734: NRO, BH5, Master's Disbursement for 13 July-10 August 1734.
[39] NRO, BH9, Minute of 13 April 1741.
[40] NRO, BH9, Minute of 27 April 1747. The wall was to have a height of 7.5 feet.
[41] NRO, BH12, Minute of 3 February 1800.
[42] NRO, BH1170/28.

Particularly in earlier years, though, the walls of Bethel Hospital were more porous for patients than their monolithic appearance might suggest.[43] At Bethel, some patients were likely offered a greater deal of mobility than others at the discretion of the Master, with some even being allowed to leave the premises temporarily. The board apparently pushed back against such practices by resolving in 1753 "that the Master do not suffer any of the Lunatics to go out of the House without an Order in Writing" signed by two or more trustees as well as the hospital's physicians.[44] The Rules and Orders of the Hospital adopted in 1797 went further to order that "no Patient be […] sent out of the House on ~~Errands.~~ any account whatsoever."[45] The specific mention of errands here implies that some patients had previously actually been sent out of the hospital to perform tasks for its staff. This would have constituted a highly significant extension of mobility for patients that sufficiently endeared themselves to the hospital staff by proving themselves serviceable. Indeed, it provided a very lucrative opportunity to escape, which is likely why the practice was ended. Even after the board effectively banned patients from ever leaving the property prior to discharge, however, patients were still able to increase their general mobility within the institution by acting as servants. For instance, typically female patient-servants were allowed in the "cooking Room or the Matron's sitting Room," a spatial privilege not normally afforded them.[46]

Over time, managerial concerns also drove hospital administrators to institute the spatial separation of patients into different groups. The gendered segregation of male and female space

[43] As Lloyd Parry-Jones similarly noted in his foundational study of private madhouses, "A greater degree of liberty appears to have been allowed to the convalescent or well-behaved patient than has generally been considered the case": Parry-Jones, *The Trade in Lunacy,* 184.
[44] NRO, BH9, Minute of 2 July 1753.
[45] NRO, BH24.
[46] NRO, BH24. The advantages servanthood offered patients are further discussed in Chapter Three.

became a major feature of the hospital's layout starting in 1747, when partitions were built to separate mens' and womens' cells. With this new gender segregation, the Master now presided over the male patients and the Matron over the female patients, a major expansion of the Matron's role.[47] This gender segregation of wards was common in contemporary lunatic and general hospitals as a preventative measure against abuses (from other patients as well as from staff).[48] This new institution of gendered space undoubtedly would have had major effects on the general nature of social interactions between patients, as well as between patients and staff.[49] It became another boundary for the hospital administration to police. Times of overcrowding strained the rigor of this segregation, however; in 1797, the board noted that "some of the Female Patients appear to be improperly placed in a Cellar on the Mens side of the Hospital" and thus ordered plans be made to construct six more cells "at the end of the Womens Kitchen."[50] As this case suggests, the boundaries separating male and female patients were likely less rigid in practice than written regulations implied.

Patients were also spatially distributed according to the severity of their violence and/or resistance to hospital authority. This practice had a long precedent at Bethlem in London as early as the 1640s, when the 'most quiet and orderly' inmates were kept in a separate wing from 'the most outrageous.'[51] In 1749 Bethel Hospital's board ordered that "the straw room […] be filled

[47] NRO, BH9, Minute of 9 June 1747. The 1797 Rules & Orders indicate that the Master and Matron were respectively charged with getting male and female patients up in the morning, bathing them, distributing their meals, administering medicine, and inspecting cells daily, all with the help of attendants: NRO, BH24.
[48] e.g. the Norfolk and Norwich Hospital, est. 1771, instituted gender segregation of wards as early as 1782.: Eade, *The Norfolk and Norwich Hospital, 1770-1900,* 221.
[49] For a study of influences of early modern gendered spaces on social interactions within Norwich, see Fiona Williamson, "Space and the City: Gender Identities in Seventeenth-Century Norwich," *Cultural and Social History* vol. 9 no. 2 (2012), 169.
[50] NRO, BH12, Minute of 7 July 1797; Minute of 17 July 1797.
[51] Andrews, "'Hardly a Hospital," 74.

up as a Celler for ye worst of the Lunicates [sic] to be put in," presumably referring to the most violent or resistant patients.[52] This cellar likely continued to be used for this purpose as late as 1809.[53] Board minutes also make reference at one point to a "room call'd the dark room" that was ordered to be converted into a cell accommodating two patients in 1750.[54] This may have been a room previously used for the temporary solitary confinement of particularly violent inmates, judging by the existence of similar spaces in other institutions. The threat such punitive spaces posed to patients served as a deterrent against acts of resistance.[55]

Administrators also designated separate spaces to house patients with various physical illnesses or wounds. The male and female wards each had a 'sick room' as early as 1751.[56] These were particularly necessary for the seclusion of patients with potentially communicable diseases such as smallpox. The hospital's physicians sometimes hired nurses to assist in the treatment of physically ill patients; for instance, in 1757 parish overseers were billed "for Watching & Nursing of Eliz[abeth] Delley of the Small Pox," and hospital Masters occasionally paid to board nurses at the hospital for weeks at a time.[57] Other medical treatments included dressing wounds, pulling teeth and unspecified 'surgery.'[58]

In addition to driving a continual expansion of the facilities, overcrowding also drove continual fortifications of existing physical security measures due to the challenges of managing

[52] NRO, BH9, Minute of 8 May 1749.
[53] A bill from 14 September 1809 lists as an item "Rep[airin]g lock of Cellar door": NRO, BH1172; see also the 1797 case of female patients being housed in the cellar discussed above.
[54] NRO, BH9, Minute of 28 May 1750.
[55] e.g. John Haslam, apothecary to Bethlem Hospital, recommended that "In the most violent state of the disease, the patient should be kept alone in a dark and quiet room […] such abstraction more readily disposing to sleep." John Haslam, *Observations on Insanity,* 126.
[56] NRO, BH9, Minute of 9 December 1751.
[57] NRO, PD 712/59; NRO, BH6, Master's Disbursement 10 Oct-7 Nov. 1761; Master's Disbursement 18 Sept.-16 Oct. 1779.
[58] NRO, BH1181/3/3; BH1554; BH9, Minute of 11 February 1754.

the confinement of greater patient populations. In 1756, for instance, the board ordered that a "strong partition & Door" with iron grates be built in the entrances to the men's and women's wards.[59] An inventory of the hospital from the same year reveals that locks were affixed to most doors of both communal and non-communal rooms in the main building. It also details iron grates covering the doors to the kitchens and to the Master's lodgings, hinting at staff members' continual fear of patients' potential for violence.[60] In later years attempts to fortify patient cells became more dramatic. An 1809 bill refers to "Spikes &c to Bound mens Cells," and a bill from two years earlier specifies the purchase of "20 Spikes 10 In[c]h long," presumably for the same purpose.[61] The apparent use of these measures only in cells of male patients suggests that males were considered much more dangerous, possibly in response to specific acts of violence or resistance.

The construction of new buildings on the facilities presented new challenges for maintaining the security of the premises as they offered fresh opportunities for patients to escape. Iron bars were placed on all major windows of newly constructed buildings,[62] but this was not always sufficient. In 1807 major work was started on new buildings on the grounds to act as cell blocks.[63] Although these additions allowed the hospital to accommodate an unprecedented number of patients (reaching a total of 75 by 1810), in time the new buildings were found insufficient for the purposes of confinement. In 1810 the hospital physicians petitioned the board to adopt

[59] NRO, BH10, Minute of 3 July 1756.
[60] NRO, BH16, "An Inventory of Goods at Bethel taken the 30th day of July 1756."
[61] NRO, BH1172; NRO, BH1537.
[62] NRO, BH9, Minute of 20 August 1750; NRO, BH10, Minute of 7 June 1762.
[63] NRO, BH12, Minute of 5 January 1807. These were possibly two L-shaped buildings that were demolished around 1830; thus no surviving maps depict them in any detail: Wood et. al, *Bethel Hospital, Norwich Conservation Management Plan,* 81.

> some measures for the more effectual confinement of the patients within the walls of this Hospital _ several patients have got over the Walls and made their escape, and those who have been brought back can escape again without much difficulty. There seems to be some defect in the construction of the newly erected buildings, which continually present the opportunity for trying to escape.[64]

Soon afterward physical alterations were made to increase the security of the new buildings.[65]

The task of confining and regulating the movements of an ever-increasing patient population also motivated the hospital administration to dramatically expand the use of various mechanical restraints, including handcuffs, chains, leg locks, and strait-waistcoats (the predecessor of the 20th-century straitjacket). The physical restraint of patients with such devices was viewed by contemporary medical authorities as not only managerial, but also of therapeutic value.[66] The first reference to the use of restraints at Bethel Hospital is found in a 1743 inventory, which lists five pairs of handcuffs and two chains kept in the 'parlour.'[67] Such methods were likely in use well before this point, however. At the time of the 1743 inventory the first Hospital Master, Robert Waller, was still presiding over the institution. Having been specially chosen for the post by Mary Chapman, after her death Waller's grandiose and cruel personality quickly brought him into conflict with the Hospital board. The board fined him in 1725, noting that he had

> [cor]rected some and managed others of the s[ai]d Lunaticks in an undue manner and upon this discourse had with him on these occasions has used several contemptuous expressions against the s[ai]d Trustees declaring that he would not be directed by any man […][68]

It is unknown what sort of 'undue' methods of correction the board referred to. Waller kept his

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[64] NRO, BH12, Minute of 1 January 1810. The same report specifies that two patients had escaped in the previous year.
[65] NRO, BH12, Minute of 8 January 1810.
[66] Parry-Jones, *The Trade in Lunacy,* 171.
[67] NRO, BH16, "An Inventory of the Goods at Bethel taken __January 10: 1743." These figures may have excluded chains in use at the time, judging by the fact that all three surviving inventories of the hospital (c. 1743, 1756 and 1776) only mention restraints in storage spaces.
[68] NRO, BH16, Minute of 28 June 1725.

post even after this incident, however (perhaps his erstwhile personal connection to Chapman made the board hesitant to go against her wishes). He was finally forcibly removed by the board with "just cause of complaint" at the end of 1743.[69]

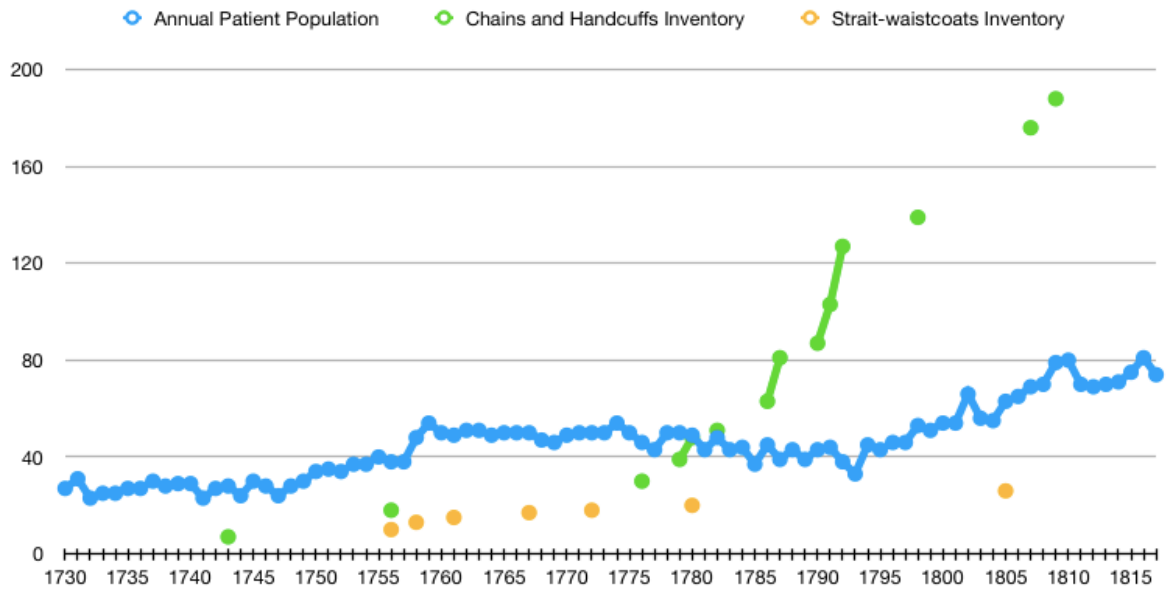

Figure 2.9 - Mechanical Restraints and Patient Population Over Time

In Waller's wake, however, the number and variety of mechanical restraints employed in Bethel only continued to grow. A 1756 inventory lists nine chains, five handcuffs and four "Legg locks" in storage. It also lists ten 'Waistcoats' alongside these restraints[70] - presumably these were strait-waistcoats, designed to absolutely constrict the wearer's arms. Strait-waistcoats had first been adopted by English mad-doctors sometime in the first half of the 18th century as a more sophisticated and supposedly more humane alternative to chains.[71] The board of Bethel

[69] NRO, BH16, Minute of 19 December 1743.
[70] NRO, BH16, "An Inventory of Goods at Bethel taken the 30th day of July 1756."
[71] Richard A. Hunter and J.G. Widdicombe, "The Strait-Waistcoat: An Early Unrecognised Form of Collapse Therapy," *The British Journal of Tuberculosis and Diseases of the Chest* vol. 51 no. 2 (April 1957), 147. The specific origin of strait-waistcoats remains unclear, but they were evidently in use as early as 1739 at private madhouses.

Hospital had first ordered these waistcoats to be specially made "for the Lunatics" in 1755.[72] The board occasionally ordered more small batches of strait-waistcoats be made for "the disorderly Lunatics" over the following decades (see Figure 2.9).[73]

A waistcoat could apparently be reserved for the restraint of a single patient over an extended period of time; a disbursement from 1758 includes a charge for "mending [John] Mottram's Waistcoat."[74] Such long-term employment of strait-waistcoats would have had highly detrimental effects. Theoretically the strait-waistcoat offered greater spatial mobility than chains as it left the patient's legs untethered, but this came at the cost of a total restriction of the upper body. As John Haslam noted in his practice at Bethlem Hospital, straitjacketed patients could not feed themselves, clean or otherwise care for themselves, and over an extended period of time would often experience respiration problems (if the waistcoat was tied too tightly) and a permanent atrophying of the arms and hands.[75]

The use of strait-waistcoats at Bethel Hospital always held a secondary role, however, to the much more prevalent usage of chains and handcuffs. For the first fifty years of the hospital's operation, the number of chains, handcuffs, etc. grew roughly in step with the growth of the patient population. In June 1776, when an inventory recorded 30 mechanical restraints (not including strait-waistcoats), there were 46 patients in the hospital.[76] Starting in 1787, however, the number of mechanical restraints began to rapidly outpace the patient population, with the

[72] NRO, BH10, Minute of 5 May 1755.
[73] e.g. NRO, BH10, Minute of 24 July 1758; besides the minute books, the other major source for waistcoat purchases are the Books of Master's Disbursements: NRO, BH5, BH6, and BH7.
[74] NRO, BH5, Master's Disbursements 22 July-19 August 1758.
[75] Will Wiles, "'Straitjacket': A Confined History," in *Insanity and the Lunatic Asylum in the Nineteenth Century,* ed. Serena Towbridge (New York: Routledge, 2016), 170-171.
[76] NRO, BH11, Minute of 3 June 1776; Ibid., "An Inventory of the Goods & Chattels belonging to the Governors of this Hospital taken in June . . . . 1776."

board regularly ordering large and small purchases of chains, handcuffs, leg locks, and 'waist locks' throughout the 1790s and 1800s (see Figure 2.9). Throughout the period under discussion, the total number of mechanical restraints purchased by the hospital grew by more than twenty-fold to reach a prospective total of 188 by 1810.[77] By this time the hospital contained a total of about 80 patients. The number of attendants in this period is unknown, but 19th-century maps suggest that there were no more than nine, connoting a maximum attendant-to-patient ratio of 1:11 by this time.[78] It is possible that times of overcrowding, especially in this later period with the new building security concerns outlined previously, drove the hospital administrators to rely increasingly on mechanical restraints to supplement punitive architectural features in ensuring the confinement of patients to the hospital grounds. Indeed, by the end of the period the hospital had enough chains at its disposal to theoretically bind both the hands and legs of every single inmate it accommodated. It is unlikely that such a great number of patients were ever actually restrained in this manner at a single time, however. Storing such large numbers and varieties of restraints simply lent hospital attendants more versatile tactics to combat individual acts of resistance in the hospital's day-to-day functioning.

[77] This tentative final figure of 188 combines the recorded inventory of 30 chains and handcuffs in 1776 with the figures of all recorded purchases made 1776-1811.The figures of recorded purchases are drawn from the following sources: NRO, BH5; NRO, BH1537; NRO, BH12; NRO, BH1172. It is possible that some of the oldest chains were eventually replaced with new ones, but even as late as 1807 it seems that "Old Chains" were still generally being 'mended' rather than discarded: NRO, BH1537.

[78] The late 19th-century maps show a total of 14 rooms designated for attendants on the grounds, nine of which are located in the wards within the 18th-century parameters of the building: NRO, BR 35/2/94/3/1-21. By comparison, the ratio at the York Retreat was approximately 1:8, a figure which Anne Digby asserts was favourable compared to other institutions and sufficient to institute its policies of non-restraint: Anne Digby, "Moral Treatment at the Retreat, 1796-1846," in *The Anatomy of Madness: Essays in the History of Psychiatry* Volume II, eds. W.F. Bynum, Roy Porter, and Michael Shepherd (New York: Tavistock Publications, 1985), 58.

Besides traditional restraints, the hospital's Masters also purchased at least two "Bath Chairs" — an early form of wheelchair invented at Bath in the early 18th century. The first Bath Chair was purchased for Bethel Hospital in 1735, and a second "Rope Bath Chair" was purchased in 1779.[79] In a lunatic hospital, such devices would have allowed mobility for patients that were unwilling or unable to move in accordance with hospital attendants' wishes.[80] Bath Chairs would have allowed attendants to simultaneously totally restrain and move patients at their will (the term "Rope Bath Chair" potentially implies a form of restraint with ropes built into the device). It served as yet another tool for the hospital staff to attain greater control over the restraint and mobility of the patients.

2.3 Tracing Shadows - Patients' Movements and Spatial Experiences

So far, the narrative developed here has privileged the perspective of hospital administrators attempting to manage the confinement of a large number of inmates. This is primarily due to the constraints of the surviving evidence concerning the institution, which was almost wholly created by the hospital's board and staff. It is equally important, though, to consider the movements of the patients deemed mad and kept within the hospital's walls. In

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[79] NRO, BH5, Master's Disbursement 14 June-12 July 1735; NRO, BH6, Master's Disbursement 21 August-18 September 1779; The most commonly cited date for the invention of the three-wheeled Bath Chair is around 1750, but its predecessors likely date to a much earlier date. The phrase appears in print with a similar apparent meaning at least as early as 1672: Richard Baxter, *The Life & Death of That Excellent Minister of Christ Mr. Joseph Alleine* (London: J. Darby, 1672), 142; *A History of the World* (BBC), s.v. "Bath Chair." http://www.bbc.co.uk/ahistoryoftheworld/objects/qcI7cMgiR0qmLnD_QPyIGQ; Herman L. Kamanetz, "A Brief History of the Wheelchair," *Journal of the History of Medicine and Allied Sciences* vol. 24, no. 2 (April 1969), 209.

[80] It is unlikely that the bath chairs were used for facilitating the movements of physically disabled patients, as the revelation of any serious persistent physical condition (e.g. epilepsy, deafness, or being 'infirm') tended to result in a patients' discharge from Bethel as 'unfit': e.g. NRO, BH12, Minute of 2 July 1798; Minute of 6 January 1800; Minute of 7 July 1806.

practice, how effective were these architectural and mechanical strategies of confinement at restricting the mobility of patients within Bethel Hospital? What characterized patients' general daily experiences and perceptions of the Hospital's spaces over time? Finally, how were patients able to resist the impositions of the institution and re-appropriate its space through distinctive non-legitimized movements and actions?[81]

The challenges and potential problems of determining a 'general experience' of Bethel hospital's inmates from extant evidence are many. As outlined previously, an individual patient's spatial experiences of the hospital could differ from those of others based on many considerations funneling them between different sets of designated spaces. There are ways, however, to indirectly speak to different general aspects of patients' perspectives without ascribing a single identity to all of them. Outside of Bethel Hospital's records, one distinctive source for patients' perspectives on lunatic hospitals are the writings of James Tilly Matthews, who was confined to Bethlem Hospital in London for nearly twenty years starting in the mid-1790s. Recognized for his unusually intellectual pursuits in confinement, in 1811 he actually drafted plans for the new Bethlem Hospital building and submitted them to a public competition. Matthews' plans are a unique source, presenting many ideas for how to improve the situation of Bethlem's inmates through revamped architecture and, in doing so, drawing on not only his own experiences in the institution, but also on those of his fellow inmates.[82] Matthews' experiences of Bethlem may be instructive for understanding the perspectives of patients in Bethel. Bethlem

[81] I am employing theoretical concepts formulated by De Certeau, *The Practice of Everyday Life,* xiv; and Philo, "One Must Eliminate the Effects of … Diffuse Circulation," 495.
[82] Mike Jay, *The Influencing Machine: James Tilly Matthews and the Air Loom* (London: Strange Attractor Press, 2012), Kindle edition, Chapter 7.

was indeed a much larger institution in scale, but the general forms of architecture and techniques of restraint in the two institutions are comparable in this time period.[83]

To an extent, the daily movements of Bethel Hospital's patients were determined by hospital authorities. There existed a certain tension between the stated imperative of confinement and contemporary therapeutic prescriptions that a "certain amount of freedom" in mad patients' movements would aid in their recovery.[84] Thus one of the roles of lunatic hospitals as institutions was not only to prevent patients from straying outside designated spatial boundaries, but also to regulate, indeed to enforce, their daily sanctioned movements.[85] Bethel Hospital's Rules and Orders decreed that patients were to rise at 7 a.m. or 'by Day Light' in winter. At this time each 'Lunatick's' face and hands were to be washed, and patients who the physicians prescribed to be bathed would be taken to the Washhouse under the Master or Matron's supervision. From there, breakfast would be served in the gender-segregated kitchens, then lunch at 12 p.m., then supper at 5:30 p.m. followed by bedtime at 6. From 6 pm until 7 am the following morning, patients would be confined to their cells, undergoing a daily inspection of their quarters before 9 p.m. by the Master or Matron.[86] Between mealtimes, patients were likely allowed in common spaces of some kind; locks placed on the doors to wards suggest that the corridors may have served as common spaces prior to the construction of specific day rooms, as was the case at St. Luke's

[83] Architecturally, both Bethlem and Bethel were modelled on the designs of great houses, with cells running along a central block accessed by a single corridor and wings projecting from either side of the central block: Arnold, *The Spaces of the Hospital,* 43; Yanni, *The Architecture of Madness,* 18. Bethlem's administrators also presided over a largely stagnant regime of mechanical restraints and humoural treatments over the 18th and early 19th century, as did Bethel's: Leonard D. Smith, *'Cure, Comfort, and Safe Custody*, 248.
[84] Stevenson, Medicine and Magnificence, 206-207.
[85] Philo, "One Must Eliminate the Effects of … Diffuse Circulation," 497.
[86] NRO, BH24; NRO, BH16, "An Inventory of Goods at Bethel taken the 30th day of July 1756"; NRO, BH16, "An Inventory of the Goods at Bethel taken January 10: 1743"; NRO, BH10, "An Inventory of the Goods & Chattels belonging to the Governors of this Hospital taken in June . . . . 1776."

Hospital in London. Patients could also be allowed in the front yard as well as the back courtyard, as indicated by the board's concerns over patients speaking to "com[m]on people" at the front gate in 1769.[87] As this concern suggests, the outdoor common spaces were where patients were most able to retain a sizeable degree of autonomy over their movements and actions, even managing to make unsanctioned contact with the outside world.

How might the architecture of Bethel Hospital have been perceived by those held within it? Many of Bethel's patients had experienced multiple institutional environments as they were targeted for confinement by different legal authorities.[88] Some came to Bethel directly from gaols, Bridewells, Houses of Correction, or the workhouses in Norwich. In this context of common trans-institutionalization, it is likely that Bethel Hospital's patients tended to view its architectural features as essentially penal and punitive. From the start, the building's cells, iron bars in windows, and other features were similar to those of the city's Bridewell, which continued to hold a significant proportion of the city's 'lunatics' in the period under consideration.[89] Such penal elements, especially iron bars, were harshly criticized by Bethlem patient James Tilly Matthews, who asserted that barred windows

> give to the front of the building next the public that hateful prison look, and as nothing makes a stronger impression on deranged minds than the appearance of the place they are brought to inhabit, the prison application thereof often produces so strong an effect as renders the skilful doctor's efforts useless.[90]

[87] NRO, BH1537; NRO, BH10, Minute of 7 August 1769; Yanni, *The Architecture of Madness,* 21.
[88] Parry-Jones, *The Trade in Lunacy,* 7.
[89] Dittbrenner, "The Poor Law and the Problem of Poverty in Norwich and Norfolk, 1660-1760," ch. 4, 14; Mark Griffiths, "Inhabitants," in *Norwich Since 1550,* eds. Carole Rawcliffe and Richard Wilson (London: Hambledon and London, 2004), 79, 85.
[90] Bethlem Royal Hospital Archives, London, PPJ-01 (James Tilly Matthews' Plans for the New Bethlem Hospital: The Deuce Take It), quoted in Jay, *The Influencing Machine,* Kindle edition, ch. 7.

Additionally, the extensive use of chains at Bethel was in fact far more punitive than, for instance, the practices at the House of Correction or Bridewell in Wymondham, Norfolk, where multiple patients at Bethel had previously been confined.[91] In prison reformer John Howard's 1788 survey of English prisons, he approvingly noted that "none of the prisoners [were] in irons" in the Wymondham Bridewell.[92]

In spite of such mechanical restraints, however, Bethel's patients likely still found ways to resist their imposition. Matthews relates that Bethlem's chained inmates used the small amount of mobility offered to them by chains to bar attendants from entering their cells, or to endlessly slam their inner cell door open and shut to create a tremendous noise.[93] A similar noise-related form of resistance is attested to by John Haslam, apothecary to Bethlem in the same period, who describes patients shaking their chains for hours on end.[94] These are the kind of tactics James C. Scott has termed 'weapons of the weak' - individual, everyday acts of resistance by relatively powerless groups, through which power relations are continually negotiated.[95] In a position where an individual's physical mobility is restricted, the production of oppressive or transgressive sound may have served as an expression of patients' little remaining autonomy, in an effort to quite literally be heard.

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[91] e.g. James West and William Buttell: NRO, BH10, Minute of 14 December 1757; NRO, BH12, Minute of 11 November 1799; NRO, PD100/142.
[92] John Howard, *An Account of the Present State of the Prisons and Houses of Correction in the Norfolk Circuit* (London: Society… against Vice and Immorality, 1789), 16. Notably, on Howard's first inspection of the institution in 1777, every prisoner had been in chains: John Howard, *The State of the Prisons in England and Wales* (Warrington: William Eyres, 1777), 260-261.
[93] Jay, *The Influencing Machine,* Kindle edition, ch. 7.
[94] Haslam, *Observations on Insanity,* 26.
[95] James C. Scott, *Weapons of the Weak: Everyday Forms of Peasant Resistance* (New Haven: Yale University Press, 1985), 29-30.

Such forms of resistance are not explicitly recorded at Bethel in the period under discussion. However, the resignation of one of the board's trustees, Samuel Wiggett, in 1757 hints at the sonic and visual environment collectively created by the hospital's patients. Wiggett explains that "my Spirits are exceeding Weak. I cannot bear to *hear and see*. *These melancholy Objects.*" (emphasis added).[96] This phrasing is elusive, but at the least, it implies that the hospital was a place of great suffering for its patients. It further hints that the sounds patients made - with their voices or by other means - were evidently obtrusive enough to motivate a trustee (that likely did not visit the hospital building more than once per month) to resign his post.[97]

Additionally, there was at least one incident at Bethel that dramatically illustrates the mobility and violent force patients could wield even while in chains. In 1750, a coroner's inquest was conducted on the body of one Richard Perrin, a patient at the hospital. The jury concluded that at around 2 p.m. another patient, Henry Case, had picked up a loose wooden board laying nearby and "notwithstanding his being in some measure pinioned [i.e. restrained]" he struck Perrin several times on the head, killing him instantly.[98] The time of the murder implies that it likely occurred in one of the hospital's common spaces. One potential spot it may have taken place was in a corridor adjacent to a block of four cells above the Washhouse, where there were "sundry sorts of boards and pieces of wood" as reported in an inventory six years later.[99]

This case first demonstrates that chains or other mechanical restraints did not always effect a complete restraint of a patient's mobility. Simultaneously, the event reinforced the

[96] NRO, BH10, Minute of 27 June 1757.
[97] Regular visitation of the grounds by board members outside of the monthly gathering for meetings was not formalized until a resolution in 1776: NRO, BH11, Minute of 4 March 1776. Wiggett had, however, overseen the inventory of the hospital taken in 1756, which would have brought him in much closer contact with the hospital's patients than usual: NRO, BH10, Minute of 23 August 1756.
[98] NRO, NCR 6a 7/148; Perrin's patient status is revealed by board minutes: NRO, BH9, Minute of 12 December 1748.
[99] NRO, BH16, "An Inventory of Goods at Bethel taken the 30th day of July 1756."

administrators' rationale of restraint; here was the horrific violence of madness, what the hospital staff feared most, exacting its full force. However, it is worth noting that the same mechanical restraints that Henry Case was able to transcend may have also been the very thing that prevented Richard Perrin from defending himself. In the constraints of the institutional environment, more vulnerable patients could be placed at the mercy of anyone: attendants, physicians, or fellow patients. There is little wonder that James Tilly Matthews spoke so strongly against multiple patients being housed in the same cell, "such being improper, as tending oftener to excite than to prevent detestability."[100]

Besides extraordinary acts of violence, a more common form of resistance can be seen in escapes and escape attempts. Surviving hospital records are typically silent on escapes; no specific escapes are recorded in the board minutes and are in fact not mentioned at all until the physicians reported to the board about the prevalence of escapes at the end of 1809. This report reveals that two patients had successfully escaped from the hospital permanently in the past year, and several more had escaped before being brought back.[101] The surviving patient registers (encompassing approximately 1790-1819) reveal at least three other cases of patients who successfully "broke out" of the hospital.[102] Prior to this period, as discussed above, policies barring patients from leaving the hospital on errands hint at potential escapes or escape attempts that may have prompted the board to completely resolve against the practice in 1797.[103]

Escapes perhaps constituted the most effective resistance to the institution's power. The hospital's urban location likely eased the ability of escaped patients to avoid being apprehended and returned to the hospital grounds, compared to asylums located in more isolated areas of the

[100] Bethlem Royal Hospital Archives, PPJ-01, quoted in Jay, *The Influencing Machine,* ch. 7.
[101] NRO, BH12, Minute of 1 January 1810.
[102] NRO, BH77; BH78.
[103] NRO, BH24.

country. If the ex-patients proceeded to behave in a socially aberrant or transgressive manner, however, they might simply be confined again. In 1810, the *Bury and Norwich Post* described a man "supposed to be intoxicated" who walked into a bank in Norwich and demanded £500. When this request was denied, the paper relates, "he behaved in a very insolent and riotous manner." After being apprehended by authorities and refusing to state his name or place of origin while using "improper language," the man was committed to the city's Bridewell. Soon the authorities determined "that he was in a deranged state of mind, and had escaped from Bethel about five weeks ago." (the timing of the incident suggests that he may have been one of the two patients reported to have successfully escaped in 1809). Instead of being returned to Bethel, however, he was instead entrusted to the care of his friends. This incident is revealing of the kinds of behaviour leading to the label of lunacy, as well as rationales of confinement. The man was not reported to have been physically violent, but his open insubordination in refusing to give an account of himself before authorities meant that "he was not in a state to be trusted alone." Once it was determined that he had friends, however, confinement no longer seemed imperative.[104] Thus decisions of confinement likely tended to weigh against the socially isolated.[105]

Even despite conditions of confinement and restraint, there is reason to believe that at least some of Bethel Hospital's patients were able to find small comforts that helped them to survive the ordeals of the institution. In architectural plans drafted from his cell in Bethlem, James Tilly Matthews focused particularly on the value of being able to view the outside world. In his plans, Matthews illustrated with great particularity the views that patients in different

[104] *Bury and Norwich Post,* Wednesday 17 January 1810, 3.
[105] Geoffrey Reaume also notes this trend in his study of the Toronto Hospital for the Insane's patients: Reaume, *Remembrance of Patients Past,* 45.

wings would have of the courtyards, allowing them to partake in observing the goings-on of the public or of other patients outside.[106] Patients housed on Bethel Hospital's first and second floors likely had similar views of the public to engage with, another small advantage of the hospital's central urban location. In fact, not only could patients view and hear members of the public, they could also engage with them in more personal ways. In her memoirs, novelist Amelia Opie fondly recalls her memories of interacting with Bethel patients at a distance as a child in the 1770s, particularly one patient named Goodings. Opie's account is worth quoting at length:

> I […] took care to shew a penny in my fingers, that I might be asked for it […] A customer soon appeared at one of the windows, in the person of a man named Goodings, and he begged me to throw it over the door of the wall of the ground in which they walked, and he would come to catch it. Eagerly did I run to that door, but never can I forget the terror and the trembling which seized my whole frame, when, as I stood listening for my mad friend at the door, I heard the clanking of his chain! nay, such was my alarm, that, though a strong door was between us, I felt inclined to run away; but better feelings got the mastery, and I threw the money over the door, scarcely staying to hear him say he had found the penny, and that he blessed the giver.[107]

Such small yet significant interactions allowed patients to break the monotony of their days and retain a tenuous connection to the outside world, even as they were forcibly segregated from wider society.

Views from inside the cell windows were always framed by iron bars and courtyard walls, a constant reminder of the stark separation between the public community the patient observed and the carceral institution to which they were confined. Nonetheless, as this chapter has suggested, patients' confinement and the institution's power over patients' movements within its walls were never absolute, and patients had diverse tactics at their disposal to resist the constraints of the building's architecture, the impositions of mechanical restraints and the

[106] Jay, *The Influencing Machine,* ch. 7; Mike Jay, *This Way Madness Lies: The Asylum and Beyond* (London: Thames & Hudson, 2016), 86.
[107] Opie, *Memorials of the Life of Amelia Opie,* 15.

regulatory regime of the hospital's staff in ways both big and small. To borrow Carla Yanni's evocative phrase, the hospital persistently proved itself to be 'a place of struggle':[108] a place of administrative authority diluted by architectural oversights, of chains which both protected and harmed, of conflicting wills, of stark violence masked by allusive language. Here were the supposed dangerous forces the institution sought to keep at bay from wider society by implementing a greater systematic force. But here too, as Amelia Opie's account indicates, were all sorts of people from a variety of backgrounds who were effectively trapped beneath the label of lunacy. Who were they? What were the circumstances that brought them into the walls of Bethel Hospital? We now turn to consider their stories in greater detail.

[108] Yanni, *The Architecture of Madness,* 15.

3

Living in the Shadow of Madness: Patient Experiences

> *[…] as the window was open I could talk with Goodings and the others; but my feelings were soon more forcibly interested by an unseen lunatic, who had, they told me, been crossed in love, and who, in the cell opposite my window, sang song after song in a voice which I thought very charming.*[1]
>
> — Amelia Opie

> *Surely oppression maketh a Wise man madd.*
>
> — Framed Bible verse in Bethel Hospital's boardroom[2]

In the fall of 1794, Francis Bowness, the head of a household in Lowestoft, Suffolk, reported recent unsettling events. The trouble was related to one of the servants at the house named Betty Byford, a young cook who had become afflicted with a

> mental disorder which increas'd so rapidly & to such an excess that I have been under the necessity of keeping ^her here & getting a person or two to be continually with her day and night […] it may be deem'd proper to get her into the Bethel at Norwich.[3]

The exact nature of this disorder was unclear. Bowness thought it a love-related melancholy, but admitted that "the apothecary […] seems to think that there is something more that disturbs her." Byford was thus taken to Norwich (a 30-mile journey) and examined by Dr. Richard Manning at Bethel Hospital. However, she was refused admission when he discovered indications that she was pregnant. In the lack of the institutional option, Bowness sent Byford into the care of her

[1] Opie, *Memorials of the Life of Amelia Opie,* 15.
[2] A frame containing this and other Bible verses was kept in the boardroom, in accordance with Mary Chapman's will, at least as late as 1743: NRO, NCC will register Lawrence 219; NRO, BH16, "An Inventory of the Goods at Bethel taken January 10: 1743."
[3] NRO, BOL 2/113/16, letter of Francis Bowness to Mrs. Peach 23 October 1794.

parents at Bury St. Edmunds. Bowness expressed with relief that "my house is again restor'd to its wonted tranquility."[4]

It may seem a bit strange to begin a chapter on patients' experiences with the story of a woman who did not actually become a patient at Bethel Hospital. But Betty Byford's experiences speak to aspects of many patients' lives that remain hidden from our view when understood only through the prism of administrative or legal records: aspects such as the interaction between familial and institutional forms of care for people deemed mad; the socioeconomic and gendered circumstances potentially contributing to an individual's mental suffering; and the place that Bethel Hospital held in the communities surrounding it, not just in Norfolk, but in adjoining counties as well. As we will see, the patients of Bethel Hospital came from a wide variety of backgrounds, places, and circumstances, but were united by the labels of madness that were applied to them. Many were poor and isolated, some well-off and well-connected. Some had only one short stay in the hospital, while others were in and out of it for the majority of their lives. Some reacted to their confinement with violence. Others harmed themselves. Many evidently harmed no one at all, instead complying with the institution or even advancing their situation by acting as servants within it.

Regardless of the circumstances of an individual's stay at the hospital, though, the stigma surrounding confinement tended to follow them back out into their communities. Luckily, as we will see, at least some former patients had each other to provide mutual support as they faced the social and economic difficulties of having been deemed mad. Sadly, others were less fortunate. Betty Byford's story places these patients' experiences in context, to show that Bethel Hospital was not the only option for individuals struggling with mental difficulties. It was rather only one

[4] NRO, BOL 2/113/16; NRO, BOL 2/113/17; NRO, BOL 2/113/15.

of many ways that communities in Norfolk and beyond attempted to grapple with the problems such individuals posed in their day-to-day lives: problems of incomprehensible speech-acts reflecting discordant inner worlds, of a sudden inability to work or undertake other life responsibilities, or in more severe cases, risks of violence or self-harm. These were individuals faced with the seemingly insurmountable task of attaining the resolution of both their inner strife and their relations to others in the shared world, a world from which they had found themselves increasingly estranged.

3.1 Socioeconomic Factors in Patients' Lives

So far, I have described the individuals my study concerns first and foremost as patients. But we must keep in mind that by and large, this is not likely to be how they primarily defined or viewed themselves. We may attain a fuller appreciation of patient identities, as well as the factors that contributed to their confinement, by considering their activities prior to their stays at Bethel Hospital. Unsurprisingly in a city dominated by the textile industry, it appears that a number of Bethel's male patients had been weavers by trade. For instance, Robert Wells, a Norwich man identified by Bethel's governors as both a Worsted weaver and a 'lunatic', was admitted in 1767, and another weaver named Philip Millgan was admitted for one month in 1761.[5] An onset of apparent madness could indeed entirely derail one's occupation. John Scott, a married man from Norwich first admitted in 1813 at the age of 34 for exhibiting 'general delusion,' was later described as having been "formerly a baker."[6]

[5] NRO, BH10, Minute of 27 April 1761; Minute of 4 May 1767. Weavers had significant life stressors. Despite the size and significance of Norwich's textile industry in the 18th century, worsted weavers in particular found themselves increasingly financially insecure as industrialization gained a foothold and their wages failed to rise in step with food prices: Dittbrenner, "The Poor Law and the Problem of Poverty in Norwich and Norfolk, 1660-1760," 4.
[6] NRO, BH78; BH46.

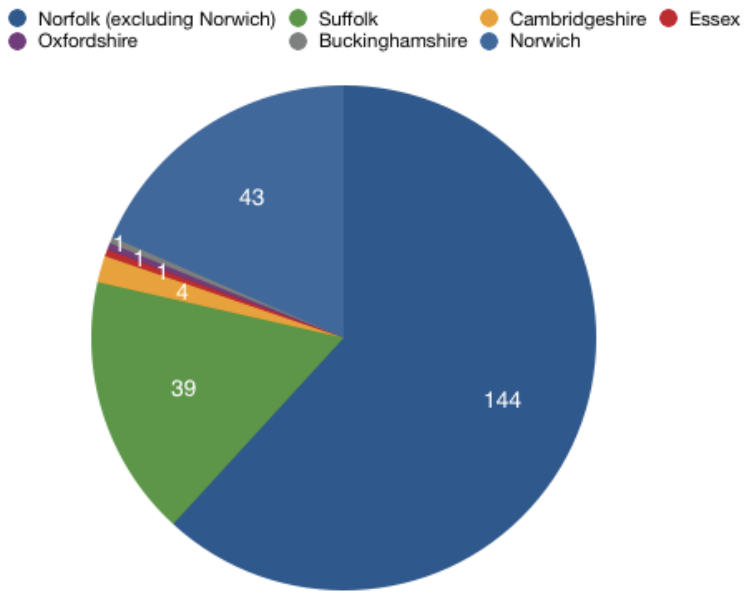

Figure 3.1 - Patients' Recorded Counties/Communities of Origin

Individuals originating from outside Norwich, who together made up the majority of Bethel's patient population (see Figure 3.1), had more diverse occupations. Benjamin King, originally from the parish of Halvergate, completed a seven-year apprenticeship to a shipbuilder in coastal Great Yarmouth in December 1801 before being admitted to Bethel less than a year later. He was discharged two months later as recovered.[7] A particularly unique patient was William Bringman, "a private Man in the Lincolnshire Militia now Quarterd in Norwich (who was admitted by special Order)" and was discharged from Bethel in 1794.[8]

In the early modern period, the socially constructed distinctions between 'men's work' and 'women's work' were relatively sharp. Typically, women's work was expected to be domestic.[9] Thus some of Bethel Hospital's female patients had worked as household servants.

[7] NRO, Y/C/19/41, 354; BH12, Minute of 6 December 1802. The parish of Halvergate is located about nine miles from Great Yarmouth.
[8] NRO, BH12, Minute of 3 November 1794.
[9] R.A. Houston, *Madness and Society in Eighteenth-Century Scotland* (Oxford: Oxford University Press, 2000), 232.

The author Amelia Opie visited the interior of Bethel Hospital for the first time in her teenage years in the 1780s. She looked forward to the visit particularly to see the women there, including "the servant of a friend of mine."[10] Elizabeth King, a single woman originally from Shidham parish in Norfolk, was later described as having been "Housekeeper to her father" before a long series of confinements in Bethel Hospital starting in 1801 at the age of 22 and ending with her death in the hospital from old age in 1863.[11] Employment in domestic service could come with notable potential risks for women, depending on the disposition of their employer.[12]

Circumstances were particularly trying for unmarried women who worked to support their children. Elizabeth Bunn had an aging woman named Phillis Carter take care of her "young Family during her dayly […] absence at work" in the parish of Heigham in Norfolk until Carter suddenly died in 1805.[13] Bunn doesn't show up again in the historical record until six years later in 1811, when she was discharged from Bethel Hospital as recovered, before being admitted again in January 1813 at the age of 42. She was finally discharged as recovered again eight months later, apparently for the last time.[14] The process of institutionalization could be set in motion in response to an individual's sudden inability to perform the jobs required of them, as we have already seen in Betty Byford's case.[15] In the context of cases where an individual's madness became a problem for others when it affected one's capacity for economic productivity,

[10] Opie, *Memorials of the Life of Amelia Opie,* 16.
[11] NRO, BH78; BH46; BH12.
[12] David Hitchcock, *Vagrancy in English Culture and Society 1650-1750* (New York: Bloomsbury Academic, 2016), 134-135.
[13] NRO, NCR 6a/15/25 (Coroner's inquest on Phillis Carter).
[14] NRO, BH12, Minute of 2 September 1811; Minute of 2 August 1813; NRO, BH77.
[15] Before permanently releasing her from her employment, Francis Bowness noted with some regret that Betty "is a quiet servant & pleas'd me much as a cook. I have a good deal of company coming to dinner to day & Betty's total incapacity rather unhinges us." NRO, BOL 2/113/15.

it is valuable to consider the contemporary associations of madness with what was considered one of the major sins of the early modern period: idleness.[16]

For besides the individuals who had held steady occupations before being brought into Bethel Hospital's walls, there were also many who, often through interrelated social factors of poverty, madness, and individual life circumstances, had neither employment nor a household in which to live. Poverty was a major problem in Norwich throughout the period under discussion. Periodic fluctuations in food prices and poor harvests drove up rates of unemployment, which sparked four major riots in the city over the 18th century.[17] There was a significant rise in vagrancy in Norwich over the same period, starting in the 1720s and accelerating in the 1740s before reaching 'epidemic proportions' in the period of the Seven Years' War (1756-1763).[18]

As David Hitchcock has argued, the fundamental societal assumption in this period regarding vagrancy was "that vagrants freely chose 'the path of mistake', that they chose to be idle." It thus tended to be viewed as a personal disorder in need of correction.[19] However, as Hitchcock found, in reality the individual life circumstances of vagrants more commonly involved personal crises and employment instability despite efforts to find work.[20] Nonetheless, an Act of 1714 allowed the apprehension and confinement of vagrants as well as 'furiously mad' lunatics by town or parish officials. In Norwich, apprehended vagrants typically were whipped and then sentenced to several months of hard labour in the Bridewell.[21]

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[16] Hitchcock, *Vagrancy in English Culture and Society 1650-1750,* 25; Foucault, *History of Madness,* 70, 77.
[17] Dittbrenner, "The Poor Law and the Problem of Poverty in Norwich and Norfolk, 1660-1760," 3. The riots occurred in 1720, 1740, 1757 and 1766.
[18] Ibid., 41.
[19] Hitchcock, *Vagrancy in English Culture and Society 1650-1750,* 24-25.
[20] Ibid., 117.
[21] Parry-Jones, *The Trade in Lunacy,* 7; Dittbrenner, "The Poor Law and the Problem of Poverty in Norwich and Norfolk, 1660-1760," 40.

Vagrancy and madness may in theory form distinct social problems, but in practice authorities' judgements often conflated the two conceptual categories. In popular as well as medical determinations of madness, people unconsciously employed collective standards of age, social status and gender in order to judge the normality of an individual's behaviour.[22] The surviving diagnoses of madness evinced by the physicians of Bethel often overlapped with condemnations of vagrancy and idleness. For instance, Dr. Warner Wright, who practiced at Bethel from 1808 until 1845, listed among symptoms of insanity in one legal case "wandering about in the night, in no pursuit & for no accountable purpose" and "inability ^to settle […] to work."[23] By definition, vagrants too were illegally 'masterless' and on the move.[24] Potential external contributing factors (economic or otherwise) behind the signs of madness or vagrancy rarely came under consideration. Wandering behaviour combined with unemployment could get one confined in a gaol or a lunatic hospital. It depended on what sort of authorities encountered the individual, legal or medical, and how their preconceptions informed subsequent decisions of what to do with them.

People considered to be both vagrant and 'lunatic' were particularly vulnerable to repeated legal apprehensions, resettlements and confinement. For instance, Samuel Corbyn was discharged from Bethel Hospital as a 'Recover'd Lunatic' in 1802. Four years later in 1806, orders were issued in the parish of Redenhall with Harleston in Norfolk to apprehend Corbyn and remove him to Denton (his parish of origin), stating that he "hath been wandring about […] and making noise and disturbances in the night time and otherwise misbehaving himself." The orders further specified that the Overseers of Denton "keep him […] locked up or otherwise

[22] Houston, *Madness and Society in Eighteenth-Century Scotland,* 226.
[23] NRO, TNA CCC HO 47/058/77.
[24] Hitchcock, *Vagrancy in English Culture and Society 1650-1750,* 92, 29.

safely confined in your said parish."[25] Corbyn then drops out of the historical record until two years later in December 1808, when he was reported to have died in Bethel Hospital.[26] Corbyn's case is particularly revealing of the ways in which vagrancy laws, parish authorities, and institutions such as Bethel worked in conjunction with each other to shuttle individuals deemed mad from place to place. It also shows that parish relief and confinement were not by any means mutually exclusive.

Not only apparent vagrants like Corbyn, but also many other poorer patients at Bethel Hospital experienced this phenomenon of trans-institutionalization, finding themselves being continually shifted between different centers of confinement with ostensibly different purposes. By the mid-1750s some pauper lunatics from Bethel that had been deemed incurable were being transferred to Norwich's two workhouses.[27] Later in the period, James Sidel was shifted from the Norwich Workhouse to Bethel Hospital in 1800, after having already recently been discharged from Bethel to his mother's care and then from his family's care to the workhouse.[28] Some of Bethel's patients, such as James West, were transferred to the Norwich or Wymondham Bridewell (where many parishes routinely sent their 'lunatics').[29] Eventually, in 1814 the Norfolk County Lunatic Asylum was established at Thorpe St. Andrews a short distance from Norwich, where a large proportion of Bethel's pauper patients were subsequently sent.[30]

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[25] NRO, BH12, Minute of 2 August 1802; NRO, PD 136/99.
[26] NRO, BH12, Minute of 2 January 1809.
[27] Dittbrenner, "The Poor Law and the Problem of Poverty in Norwich and Norfolk, 1660-1760," 26.
[28] NRO, BH12, Minute of 11 November 1799; Minute of 3 February 1800.
[29] Dittbrenner, "The Poor Law and the Problem of Poverty in Norwich and Norfolk, 1660-1760," chapter 4, 14-15; NRO, BH10, Minute of 14 December 1757.
[30] The surviving patient registers record at least 13 patients sent directly from Bethel 'to Thorpe' between 1814 and 1819: NRO, BH77; BH78. Built to house all of the county's pauper lunatics, the County Asylum apparently triggered a major depopulation of Bethel over the following years, as by 1819 external sources reported only 17 patients in Bethel, compared to 85 in the new County Asylum: Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St Andrews Hospital, 1810-1998*

More well-off patients were sometimes transferred by their relatives or friends from Bethel to private madhouses, of which there were three in Norfolk by 1807.[31] In 1756, Elizabeth Sallows was discharged 'at the request of her friends' and taken to "a Private ~~Mad~~house."[32] As a public charitable institution, Bethel was likely considered to be a second-best alternative for those who could not afford to place their relatives in a private madhouse.[33]

Besides cases of vagrancy already discussed, a number of patients at Bethel Hospital were also targeted in other legal contexts, some of them similarly connected to conditions of poverty. One of these was bastardy. The birth of illegitimate children that might become chargeable to a parish was a persistent concern of parish authorities, particularly within Norwich. In 1808, Norwich Guardians offered rewards for information regarding 'bastard' children, encouraging collective suspicion and stigma placed particularly upon unwed mothers.[34] Financially, though, parishes were more concerned with extracting payments from the children's fathers. John Strutt, first admitted to Bethel in 1809 and discharged as 'unfit to remain' a year later, had previously been ordered apprehended in 1802 for failing to make maintenance payments for two 'bastard' children he had fathered with one Elizabeth Rodwell. The warrant was not served in the end, however, as presumably he started paying. Notably, upon his 1810

(Woodbridge: Boydell Press, 1998), 40; "Return of Number of Lunatics confined in Gaols, Hospitals and Asylums in England and Wales," House of Commons Papers vol. XVII.139, 272 (1819), 2.

[31] Parry-Jones, *The Trade in Lunacy*, 34.

[32] NRO, BH10, Minute of 12 January 1756.

[33] Bethel's governors more or less explicitly expressed such sentiments in a decision to accept the application of Leonard Bacon to admit his son into the hospital in 1803: NRO, BH12, Minute of 6 April 1803.

[34] *Norfolk Annals: a Chronological Record of Remarkable Events of the Nineteenth Century (compiled from the files of the "Norfolk Chronicle")* vol. 1, ed. Charles Mackie (Norwich: Norfolk Chronicle, 1901), 64.

discharge from Bethel, Strutt was handed over to the Overseers at Tivetshall, his home parish in Norfolk. Likely he still was living in poverty, reliant upon parish relief.[35]

On the other side of the bastardy equation were women such as Mary Cooper, who was reported to have been pregnant with "a base child or children" in a 1785 document that ordered farmers John and Thomas Browne to pay for the child's maintenance in the parish of Tharston, Norfolk. Subsequently in 1802, Mary Cooper testified that she was again pregnant with a child likely to be chargeable to Besthorpe parish. She was eventually admitted into Bethel in 1810 at the age of 45 and discharged in 1812 (shortly after being treated with 'cordial' and 'astringent mixtures').[36] Similarly, Sarah Moore was reported to have had a male 'bastard' child by one William Sendall in 1795. Moore was later admitted to Bethel in 1809 at the age of 35 and died there the same year.[37] Notably, pregnant women were disqualified from institutionalization; in our period, five patients were discharged from Bethel Hospital after showing signs of being pregnant.[38] Besides economic difficulties, unwed mothers also faced considerable stigma in their communities at this time. Scholars contend that "sexual purity was the foundation stone upon which early modern female reputation rested," and a visible deviation from the norm in this sense could lead to further stigmatization and social exclusion.[39] Adding labels of madness to the mix only added yet another layer of stigma to an already challenging existence.

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[35] NRO, BH77; NRO, BH12, Minute of 7 May 1810; NRO, PD 704/205/5.
[36] NRO, PD 708/103; NRO, BH77; NRO, PD 309/57/8; NRO, BH1552.
[37] NRO, NRS 27305A/72; NRO, BH77; NRO, BH12 Minute of 4 December 1809.
[38] Mary Reeve: NRO, BH10, Minute of 4 January 1773; Grace Rackham: BH12, Minute of 2 February 1795; Mary Shirly: BH12, Minute of 5 January 1801; Sarah Phillips: BH12, Minute of 6 February 1809; Mary Bolton: BH12, Minute of 4 January 1813. No evidence survives indicating when any of these patients were first admitted.
[39] Hitchcock, *Vagrancy in English Culture and Society 1650-1750,* 127, 136.

For some particularly well-off individuals charged with major crimes, political connections helped Bethel become a more preferable alternative to gaol. In 1810, the Mayor of Norwich, Thomas Back, wrote a letter arguing on behalf of a man named Frederick Spalding held in Norwich gaol since 1807, after facing trial for an unspecified felony where he was 'found Lunatick.' Back speaks in Spalding's favour:

> The Man is well connected, has some property of his own, can be admitted […] into an excellent & well regulated Bethel in this City […] so that the publick shall not in any respect be inconvenienced by him.[40]

Accordingly, Spalding was admitted to Bethel on 3 June 1811. Despite Back's argument that if placed in Bethel "there is great Probability that he may be restor'd to a sound mind," though, Spalding's recovery evidently remained unfulfilled. Although treated multiple times in 1812 with 'Astringent Mixtures', he eventually died in the hospital in 1841 after a 30-year stay.[41]

Lastly, at least one of Bethel's patients had been charged for petty theft in their youth. Elizabeth Blyth was admitted to Bethel in 1810 at the age of 45 and died there the same year. In 1784 (at age 19), Blyth had confessed to an act of petty theft in Norwich. She had been hired by one Mary English 'to wind yarn upon quills or to do such other work' at her house and had taken an apron while Mary was away. Unfortunately for Blyth, someone else at the house had witnessed the theft. The apron was found in the possession of a pawn broker, who testified that Blyth had sold the apron to him using the rather uninspired pseudonym 'Elizabeth English.' Elizabeth Blyth marked a solitary 'X' beneath the confession, a small fragment of her existence (and illiteracy).[42] The theft of clothing was relatively common in this period, clothes being both

[40] National Archives, Kew, HO-47-41-36.
[41] Ibid.; NRO, BH78; NRO, BH1554; NRO, BH7.
[42] NRO, BH77; NRO, NCR 12b/12.

one of the most sought-after and disposable commodities.[43] Overall, given that contemporary perceptions of madness focused on acts transgressing social boundaries and standards of propriety, it is unsurprising that so many of Bethel's patients had found themselves in trouble with legal authorities at one point or another.

3.2 Living Conditions and Material Experiences of Bethel Hospital

Now that we have uncovered certain aspects of patients' lives before they entered Bethel Hospital's walls, we may turn to consider their experiences within it. Given that this study covers a span of nearly a century, it is difficult and perhaps unhelpful to make broad generalizations of what it was like for a patient to experience Bethel Hospital. As outlined in Chapter Two, patient populations and the scale of the facilities expanded dramatically over the 18th century, leading to periodic overcrowding as hospital administrators sought ways to further expand the institution's capacity. Thus the experiences of Philip Lewis, the very first patient admitted at the hospital's expense in 1725,[44] were likely radically different from those of any of the 80 patients that populated the hospital in 1810. Additionally, patients' experiences of the hospital could depend on a variety of factors, such as their gender, the nature of their mental and/or physical state, or whether they complied with the hospital's regime or resisted it. But keeping these considerations in mind, we may carefully glean from surviving records some understanding of patients' lives within the hospital.

Evidently, at least in the earlier years of the institution, patients brought some possessions with them to Bethel. An inventory of Richard Perrin's belongings upon his admission to the

[43] Beverly Lemire, "The Theft of Clothes and Popular Consumerism in Early Modern England," *Journal of Social History* vol. 24 no. 2 (Winter 1990), 257.
[44] NRO, BH9, Minute of 10 January 1725.

hospital was provided to the board following his murder by fellow patient Henry Case in 1750 (as discussed in Chapter Two). Perrin had been put on the foundation after his admission in 1748, meaning he was deemed sufficiently poor to be maintained at the hospital's expense.[45] Besides various items of clothing, his possessions included items such as tobacco, two pen knives, an 'Inkhorn & Knife' (suggesting Perrin was literate despite his poverty), and a 'parcel of prints.'[46] This last item is particularly intriguing. Prints had become exceedingly popular in 18th-century Britain; however, they cost three times more than a newspaper, and thus were not casually bought.[47] Perhaps Perrin collected pictures that held some personal significance to him. It is unclear whether Perrin was allowed access to any of these possessions during his time in the hospital, or whether, as in the 19th-century asylums, they were simply to be kept in storage until his discharge or death.[48] The inclusion of multiple knives in the inventory suggests that the latter may more likely be the case.

Perrin was also provided clothing by the Master in 1750 shortly before his murder.[49] The provision of clothing to some poor patients was evidently a feature of Bethel hospital from fairly early on. One of the first patients to consistently receive these benefits over a length of time was Elizabeth Larwood, who had been put on the foundation in 1756 and was subsequently provided items including shoes, aprons, gowns, shirts, handkerchiefs, Mobb-caps, coats and stockings from 1756 to 1770.[50] Likely influenced by early modern Christian precepts of charity to clothe

[45] NRO, BH9 Minute of 12 December 1748; NRO, NCR 6a/7/148.
[46] NRO, BH9 Minute of 12 December 1748; BH9, 25 June 1750 "An Inventory given to the Trustees […] of Mr Perrins Cloaths and Linnen at his coming into Bethel."
[47] Roy Porter, *Bodies Politic*, 29.
[48] Jane Hamlett and Leslie Hoskins, "Comfort in Small Things? Clothing, Control and Agency in County Lunatic Asylums in Nineteenth- and Early Twentieth-Century England," *Journal of Victorian Culture* vol. 18 no. 1 (2013), 97-98.
[49] NRO, BH5, Disbursement of Feb-March 1750.
[50] NRO, BH5; BH6.

the poor, clothing provision to poor lunatics was fairly widely instituted in 18th-century madhouses, workhouses and parishes. The practice also had its precedent at Bethlem, where small numbers of charity patients were given clothing starting in the 17th century. At Bethel, the number of patients receiving clothing provision at any given time did not typically go above seven or eight in the period under discussion.[51]

To better understand patients' living conditions, it is also helpful to examine the environment of the hospital. A 1756 inventory of the hospital, taken soon after the addition of the building's southern wings, gives some sense of patients' sleeping situations. In different cells it variously lists straw beds, 'Hopp baggs,' 'flock beds,' straw pillows and blankets.[52] The use of straw beds was typical in contemporary institutions for the mad, particularly for patients considered at risk to soil them. At Bethel 'a large number of straw beds' were still in use as late as 1857.[53] The flock beds were likely reserved for more compliant patients. The blankets were very much necessary in winter, as hinted at by the 1794 discharge of Sarah Lewis "as a Person too Infirm to be kept in this House during the cold season in particular with safety to herself." Temperatures in the (unheated) cells were likely similar to those in the Norfolk County Asylum, where Dr. Wright recorded temperatures as low as 45° F (7.2° C) in November 1814.[54]

Besides the cold, patients also had to brave the occasional intrusion of rodents and disease. Rats in the hospital are first mentioned in 1766, and rat-catching quickly became a

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[51] Jonathan Andrews, "The (un)dress of the mad poor in England, c. 1650-1850. Part 2," *History of Psychiatry* vol. 18, no. 2 (2007), 132, 137, 141; NRO, BH5; BH6; BH7. More typically, the friends or relatives of patients were required to provide them with clothing: Winston, "The Bethel at Norwich," 35.
[52] NRO, BH16, "An Inventory of Goods at Bethel taken the 30th . day of July 1756."
[53] Andrews, "The (un)dress of the mad poor in England, c. 1650-1850. Part 2," 142, 144; *Copy of the Fifteenth Report of the Commissioners in Lunacy to the Lord Chancellor* (House of Commons Papers 314, 1861), 27.
[54] NRO, BH12, Minute of 1 September 1794; Cherry, *Mental Health Care in Modern England,* 37.

regular feature of the hospital's expenses over the following decades. Most of the time the numbers of rats reported killed were relatively small, while at other times they were unsettlingly large. A record was set in 1777 with 34 rats reportedly killed at the hospital in one month.[55] Perhaps unsurprisingly, the hospital occasionally became a site for the spread of disease. Smallpox was a recurrent problem from the 1750s to the 1780s, with nurses sometimes being boarded in the hospital to help treat it.[56] Perhaps the worst outbreak of disease in the hospital, though, occurred in 1812. In February the hospital physicians reported an "unusual Sickness among the Patients, which has prevailed in this Hospital for the last two Months." In total the physicians later reported fourteen deaths at the hospital in 1812, compared to five the following year.[57]

Upon entering Bethel, patients also experienced nullifications of their identities and autonomy. By the 1780s, it was evidently standard practice for female patients' hair to be cut off upon admission, a practice endorsed by medical writers to encourage perspiration through the head.[58] As previously discussed, patients were also subject to the gaze of public visitors on a daily basis from the hospital's foundation until at least as late as 1794 (long after the infamous practice was ended at Bethlem in the 1770s).[59] In this context the common use of mechanical

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[55] NRO BH5, Disbursements Aug-Sept. 1766; Aug.-Sept. 1777; July-Aug. 1778; NRO, BH7, Disbursements July-August 1811.
[56] NRO, BH5, Disbursements March-April 1760; June-July 1781; NRO, PD 712/59/2.
[57] NRO, BH12, Minute of 3 February 1812; Minute of 1 March 1813; Minute of 7 February 1814.
[58] Amelia Opie described a female patient she saw in the 1780s "just arrived, whose hair was not yet cut off": Opie, *Memorials of the Life of Amelia Opie,* 16; Allan Ingram, "Deciphering Difference: A Study in Medical Literacy," in *Melancholy Experience in Literature of the Long Eighteenth Century: Before Depression, 1660-1800,* eds. Allan Ingram, Stuart Sim et. al. (New York: Palgrave Macmillan, 2011), 195.
[59] NRO, BH12, Minute of 4 August 1794; Leonard Smith, "'The Keeper Must Himself be Kept': Visitation and the Lunatic Asylum in England, 1750-1850," in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting,* eds. Graham Mooney and Jonathan Reinarz (New York: Editions Rodopi B.V., 2009), 203.

restraints on violent or resistant patients likely instilled a sense of shame as visible markers of deviance. In 1805 the governors of the Norwich Workhouse explained that imposing chains on misbehaving inmates "generally excites a sense of shame and contrition in the offender."[60] In such conditions of confinement and restraint, typically individuals deemed mad explicitly associated their institutional experiences with those of prisoners.[61]

Patients were able to find some small comforts despite the difficulties of their situation, however. Some made the most of the public visitation policy by interacting with the people that viewed them. Amelia Opie discusses one Bethel patient in particular named Goodings, who she developed a small friendship with as a child from behind Bethel's walls in the 1770s:

> Much of my weekly allowance was spent in buying pinks and other flowers for my friend Goodings, who happened to admire a nosegay which he saw me wear […] a friend of ours hired a house which looked into [Bethel], and my father asked the gentleman to allow me to stand at one of the windows, and see the lunatics walk. […] as the window was open I could talk with Goodings and the others; but my feelings were soon more forcibly interested by an unseen lunatic, who had, they told me, been crossed in love, and who, in the cell opposite my window, sang song after song in a voice which I thought very charming.[62]

Opie's account provides a rare glimpse into the social (and sonic) environment of Bethel Hospital. Besides talking to and accepting gifts from passersby, singing offered a notable form of self-expression in the institutional environment, a way to retain a modicum of autonomy while managing the boredom of confinement. It is also significant that patients could literally make their voices heard to the public from within Bethel's walls.

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[60] Edward Rigby, *Further Facts Relating to the Care of the Poor, and the Management of the Workhouse, in the City of Norwich* (Norwich: Bacon, Kinnebrook & Co., 1812), 45..
[61] Roy Porter, *Mind-Forg'd Manacles,* 270; Houston, *Madness and Society in Eighteenth-Century Scotland*, 383.
[62] Opie, *Memorials of the Life of Amelia Opie,* 14-15.

3.3 "I Cannot Sleep": Experiences of Madness in Bethel

There are many difficulties in understanding what it was like to experience madness in Bethel Hospital during this time period. In part this is owing to the paucity of sources directly describing patients, but it is also because many individuals were confined in Bethel under varying circumstances that make it difficult to reach any firm conclusions regarding the nature of any particular patient's mental state. Interpreting patients' words and actions as indicative of madness or sanity carries potential risks of either applying presentist understandings of mental illness indiscriminately (assuming madness as fact independent of the individual and society in which it manifests), or at the other extreme, a denial of mental illnesses' reality. As Jane Ussher has noted, extreme social constructivist approaches reduce madness to discourse in such a way that overlooks biology and materiality. More nuanced is Ussher's model of what she terms a 'Material-Discursive-Intrapsychic' approach, which acknowledges the simultaneous interplay between bodily and social materiality, the psychological states of individuals, and the discursive means by which madness is subjectively perceived and constructed in particular sociocultural contexts.[63] Ussher's model forms the basis of my own approach as I consider the words and behaviour of Bethel's patients.

It is clear that some of the patients in Bethel experienced significant suffering. One effect such suffering could have was an inability to sleep. During her visit to Bethel's interior in the mid-1780s, Amelia Opie witnessed one female patient that had just been admitted,

> who, seated on the bed in her new cell, had torn off her cap, and had let the dark tresses fall over her shoulders in picturesque confusion […] on being told to lie down and sleep, she put her hand to her evidently aching head, as she exclaimed, in a mournful voice, 'Sleep! oh, I cannot sleep![64]

[63] Jane Ussher, "Women's Madness: a Material-Discursive-Intrapsychic Approach," in *Pathology and the Postmodern: Mental Illness as Discourse and Experience,* ed. D. Fee, (London: SAGE Publications, 2000), 218-221.
[64] Opie, *Memorials of the Life of Amelia Opie,* 16.

Such an experience would likely have been classified as melancholic by contemporaries. Melancholy was often associated with or expressed in the form of religious despair by individuals suffering it in the 18th century, with some attributing their madness to possession by demons or the Devil.[65] Many diagnosed as melancholic, though, instead spoke of life events or personal circumstances (e.g. an unhappy marriage or financial concerns) as the main source of their unhappiness rather than invoking explicitly religious or medical etiologies.[66]

Bethel appears to have contained a number of melancholic individuals. Opie described the downcast countenance of another male patient she saw:

> I had seen, and lingered behind still, to gaze upon a man whom I had observed […] pacing up and down the wintry walk, but who at length saw me earnestly beholding him! He started, fixed his eyes on me with a look full of mournful expression, and never removed them till I, reluctantly I own, had followed my companions. What a world of woe was, as I fancied, in that look![67]

Opie, influenced by the sentimentality of contemporary literature, is particularly prone to describe Bethel's patients as objects of sympathy or pity, and thus to interpret their actions in this sentimental light.[68] But even allowing for possible exaggeration, it is likely that this patient was genuinely suffering. Inadvertently, Opie's account here sheds light on another aspect of patient experience — even at their most vulnerable moments, still they found themselves subject to the gaze of any strangers who happened to pass through the hospital. Opie did not consider the possibility that her own presence may have in any way contributed to this man's distress.

Opie's account also provides further insight into the kinds of aberrant social behaviour that could lead one to be deemed mad and institutionalized. During her visit to Bethel she visited

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[65] Leigh Wetherall-Dickson,. "Melancholy, Medicine, Mad Moon and Marriage: Autobiographical Expressions of Depression," in *Melancholy Experience in Literature of the Long Eighteenth Century: Before Depression, 1660-1800,* eds. Allan Ingram, Stuart Sim et. al. (New York: Palgrave Macmillan, 2011), 152-153; Porter, *Mind-Forg'd Manacles*, 264-265, 268.
[66] Ibid., 159, 168.
[67] Opie, *Memorials of the Life of Amelia Opie,* 17.
[68] Houston, *Madness and Society in Eighteenth-Century Scotland,* 406.

a female servant of one of her friends in her cell, who she was told had been 'crazed by hopeless love':

> I immediately began to talk to her of her mistress and the children, and called her by her name, but she would not reply. I then asked her if she would like money to buy snuff? 'Thank you,' she replied. 'Then give me your hand.' 'No, you must lay the money on my pillow.' Accordingly I drew near, when, just as I reached her, she uttered a screaming laugh, so loud, so horrible, so unearthly, that I dropped the pence, and rushing from the cell, never stopped till I found myself with my friends.[69]

Solitary or inappropriate laughter was considered a major signifier of madness in a society where laughter was expected to be social — it reflected the woman's focus on a hidden, private world rather than the shared world. But even the simple failure of a person's laughter to conform to expectations of what it should sound like could also be taken as a sign of instability. The patient's initial refusal or inability to enter into a dialogue by responding to Opie's inquiries also reflects one of the ways madness or melancholy could affect an individual: spurring an inability to articulate their thoughts or narratives. Sometimes the silences of 'the mad' were as significant as their words.[70] Alternately, the patient may have simply been annoyed with Opie's intrusion in her time of suffering and confinement.

Sometimes madness could spur individuals to commit violence upon others. Some were even aware of the onset of their homicidal madness as it was taking shape. One such person was 54-year-old Thomas Callaby, who was discharged from Bethel in 1805 "as unfit to remain in this Hospital" after a stay of unknown length.[71] Only a few days later, he murdered his three-year-old grandchild and stabbed his wife and daughter. At his trial, it was reported that Callaby's wife

> had heard her husband say a short time before that he should certainly murder someone, and had begged to be confined. It further appeared, indeed, that this unfortunate man knew when his fits of madness were coming on him, and that he, at those times, has been known to tie himself with ropes down to the floor.[72]

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[69] Opie, *Memorials of the Life of Amelia Opie,* 17.
[70] Houston, *Madness and Society in Eighteenth-Century Scotland,* 211, 213, 357-358.
[71] NRO, BH12, Minute of 1 April 1805.
[72] *Norfolk Chronicle* 10 August 1805 p. 2.

His was a rare case of a patient who had actually advocated their own confinement. In medical literature, Callaby's fate became an oft-cited justification for the confinement of 'lunatics' over the following decades.[73]

Some of Bethel's patients also committed violence against each other, as we have most notably seen in the 1750 murder of Richard Perrin discussed previously. Other acts of supposed violence are more difficult to interpret. William Miller, a 45-year-old man from Norwich, was admitted to Bethel on the foundation (i.e. at the hospital's expense) in 1812. The same year, he had 'several large wounds' on his back treated, suggesting that he may have been subjected to some form of violence.[74] Miller's stay at the hospital came to an abrupt end two years later in February 1814. At a special meeting of the board of governors, Bethel's Master reported that he

> found William Miller […] in a very indecent situation with another Patient who is reported by the physician to be in a state approaching to Ideotism Order'd that the said William Miller be discharged from this Hospital and that Notice be immediately given to the Clerk of the Court of Guardians in this City[75]

By this time Bethel's wards were firmly segregated by gender, so the other patient was certainly male. At first glance, this description might seem to suggest that Miller's behaviour was in some sense violent, but it requires contextualization. Contemporary prosecutions of what was termed sodomy (male-male penetrative sex) or sodomitical assault (supposed 'attempts' to have penetrative sex with other men) did not distinguish between consensual homosexual acts and genuine assaults. Additionally, as Rictor Norton has revealed, typically the instances of what we would consider genuine assaults involved "unwanted sexual solicitation" through forms of

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[73] e.g. George Nesse Hill, *An Essay on the Prevention and Cure of Insanity* (London: J. J. Haddock, 1814), 93; Forbes Winslow, *On the Preservation of the Health of Body and Mind* (London: Henry Renshaw, 1842), 197.
[74] NRO, BH77; NRO, BH1181/3/3.
[75] NRO, BH12, Minute of 21 February 1814.

manual touching.[76] Besides this problematic legal framework, a cursory discourse analysis of the term "indecent situation" invoked by Bethel's Master indicates that the phrase was used by contemporaries to describe a wide variety of actions controverting societal norms: consensual same-sex relations (including simply the act of laying down beside another man) as well as various consensual (often adulterous) and non-consensual heterosexual relations.[77] Thus we can know precious little of the actual circumstances surrounding Miller's discharge from Bethel. In the context of a time and place in which homosexuality itself was considered crime, sin, and a kind of madness,[78] separating the Master's cultural biases from his description of what he saw Miller and the other patient doing is essentially impossible.

Outwardly violent or transgressive patients are much more visible in the historical record because of their socially disruptive actions, leading some historians to assert that 'mad' or 'lunatic' were definitions that inherently indicated violence or its potential. This is a particularly common assumption in earlier studies based on legal records.[79] More recently, though, historians such as Kathleen Brian have brought attention to the way in which such a focus on homicidal madness may lead scholars to overlook "the significant ways in which the quiet, the melancholic,

[76] Rictor Norton, "Recovering Gay History From the Old Bailey," *The London Journal* vol. 30, no. 1 (2005), 46-47.
[77] e.g. *The Historical Magazine, Or, Classical Library of Public Events* vol. 4 (London: 1792), 286; *The Trial of John M'Taggart, Esq. for Adultery with the Wife of Jesse Gregson, Esq*. (London: W. Wilson, 1808), 100; Hansard House of Commons Sitting of Thursday, May 11, 1819; *The London Chronicle* Vol. 111 (London: J. Wilkie, 1812), 284; *Old Bailey Proceedings Online* (www.oldbaileyonline.org, version 8.0, 22 March 2019), June 1785, trial of JOHN MORRIS JAMES GUTHRIE (t17850629-60).
[78] Kelleher, "Reason, Madness, and Sexuality in the British Public Sphere," 304-305.
[79] e.g. Peter Rushton, "Lunatics and Idiots: Mental Disability, the Community and the Poor Law in North-East England, 1600-1800," *Medical History* vol. 32 (1988), 40; Akihito Suzuki, "Lunacy in seventeenth and eighteenth-century England: analysis of Quarter Sessions records Part II," *History of Psychiatry* 3 (1992), 33.

and the suicidal contributed to asylum life."[80] Often, rather than prompting homicidal acts, madness spurred patients to commit violence upon themselves. Some even took their own lives. In Bethel's case, the general silence of institutional records regarding suicidal individuals likely reflects administrators' longstanding reluctance to report deaths that may have a significant impact on the hospital's reputation.[81] There were three suicides of patients at Bethel that were reported as such by the hospital's records in the period under discussion. However, the consideration of Norwich coroner's inquest records reveals an additional six suicides at the hospital that went unreported by its staff, bringing the total to nine.

The first apparent suicide at Bethel Hospital was that of 56-year-old Robert Stiddeman in 1746. A coroner's inquest concluded that Stiddeman "being discomposed in his mind" had hung himself using "a piece of Worstead Stuff" tied around an iron bar in his cell at Bethel. Similarly, 53-year-old Mary Ransome was found to have hung herself with a piece of 'Hempen Cloth' in 1754, and 40-year-old Margaret Dann employed a similar method in 1757.[82] The majority of the subsequent suicides by patients followed the same basic method — a handkerchief tied around an iron bar in the window-frame of their cell and used as a makeshift noose.[83] There were some exceptions, however, such as 39-year-old Alice Whitehead, who in 1801 stabbed herself in the throat with a pair of iron scissors at Bethel. She died two hours later.[84]

The above discussed suicides apparently went completely unreported by the hospital. Another was reported not as a suicide, but merely as a death. Elizabeth Woodcock, a 50-year-old

[80] Kathleen M. Brian, "'The Weight of Perhaps Ten or a Dozen Human Lives': Suicide, Accountability, and the Life-Saving Technologies of the Asylum," *Bulletin of the History of Medicine* vol. 90, no. 4 (Winter 2016), 588.
[81] Ibid., 603.
[82] NRO, NCR 6a/7/83; NCR 6a/8/41; NCR 6a/8/85.
[83] e.g. the suicide of patient John Norman in 1806: NRO, NCR 6a/16/12.
[84] NRO, NCR 6a/16/12; NCR 6a/13/49.

patient who was married to a gardener in Great Shelton, Norfolk, was simply reported to have 'Dyed' on 18 June 1803 by the hospital Master. A coroner's inquest taken on her body reveals that she hanged herself in her cell in the 'women's upper ward' with her neck-handkerchief tied around the window shutter.[85] By this time, though, the institution was evidently experiencing a greater amount of public scrutiny. The results of Woodcock's inquest were published in the *Norfolk Chronicle*, which was at pains to establish that "In justice to the master of the Bethel […] on the Coroners closely investigating their conduct […] no blame whatever could attach to them."[86] As more local people became aware of patient suicides at Bethel, the chances of keeping subsequent deaths quiet became increasingly slim.

Thus, by the end of our period, patients' successful suicides at Bethel began to be reported as such in the Board of Governors' minutes. In 1813, the Matron of the hospital reported that Susan Ebden had "hanged herself with her Handkerchief." The governors conducted an inquiry of the servants before ordering a coroner's inquest on the body. This practice, which offered them greater control over the investigative process, appears to have become standard at the hospital. A year later, after a patient named either John or Thomas Buxton was found hanged from a cord in his cell, the governors conducted a similar investigation to ensure "that no Blame attached to any Person in the House."[87] The last apparent suicide of our period was that of Sarah Bell, who was reported to have 'drowned herself in the Cistern' in the hospital's washhouse in October 1817. An intra-institutional investigation was carried out yet

[85] NRO, BH12, Minute of 4 July 1803; NRO, NCR 6a/14/43. Notably, James Keymer, the apothecary at the hospital, was among the coroner's jury.
[86] *Norfolk Chronicle,* 25 June 1803 p. 2.
[87] NRO, BH12 Minute of 5 May 1813; NRO, NCR 6a/19/27; NRO, BH12 Minute of 5 September 1814; NRO, NCR 6a/20/13.

again prior to the coroner's inquest.[88] As across England madhouses and lunatic hospitals were being placed under tremendous public scrutiny (spurred by the parliamentary discovery of widespread abuses at Bethlem Hospital in London in 1815),[89] Bethel's governors likely came to realize that silence regarding patient deaths would hurt more than help their institutional reputation and actively sought to avoid potential associations of the hospital with abuses.

These patients that committed suicide at Bethel had certain similarities. All of them were between the ages of 35 and 60. This roughly reflects the age distribution of Norwich-area suicides as a whole in the 18th century, of which 51.5% were aged 25-50 and 27.3% were older than 60.[90] Additionally, two-thirds of the Bethel patients that committed suicide (six out of nine) were women. This aspect of the Bethel suicides seemingly goes against wider trends; Michael Macdonald and T.R. Murphy found that samples of nearly all surviving coroner's inquest records in England from 1500-1800 indicate twice as many male suicides than female suicides.[91] It is unsurprising, however, in the context of Bethel Hospital's roughly two-thirds majority female population as outlined in Chapter One. Female patients also could face additional challenges, as discussed; in particular, illicit pregnancies were regarded as a strong motive for suicide by unmarried women in this period, as well as poverty or economic difficulties. Overall, the strongest motive for suicide was likely social isolation in one form or another, which these other factors could contribute to significantly.[92] Negative social effects of institutional suicides or deaths could undoubtedly ripple outward into the surrounding community. It was reported of

[88] NRO, BH18, Minute of 1 December 1817.
[89] Suzuki, M*adness at Home,* 15.
[90] MacDonald and Murphy, *Sleepless Souls: Suicide in Early Modern England,* 252.
[91] Ibid., 247.
[92] Ibid., 270, 283.

R.W., a violent patient in the Norfolk Lunatic Asylum in 1816, that "his sister died about five weeks back in the Bethel… and his brother think that was what hurt his mind."[93]

3.4 Resistance versus Compliance in the Institutional Environment

The vast majority of Bethel Hospital's patients were likely placed there against their will. Some reacted to their new situation by resisting the impositions of the institution. Some did so through physical violence. It is important to emphasize that in the institutional environment of a lunatic hospital, it is difficult to distinguish violent acts deriving from mental pathology from the pathologization of resistance.[94] It is also worth noting that such acts of violence occurred in the context of a society which tolerated a relatively high level of visible violence (at least compared to our own). Thus violence in and of itself was not taken as a sign of pathology unless it had no evident agreed-upon justification to contemporaries.[95]

Certainly some of Bethel Hospital's patients were described as violent. Jabez Macro, admitted multiple times in the 1810s from the age of 16, was later described by a physician in 1845 as "very violent. Destroyes his Clothes - very noisy." The tearing of one's clothing was a well-recognized expression of personal distress.[96] Some female patients, too, were described in similar terms. Elizabeth King, who had been frequently confined in the hospital on many occasions starting in 1801, was later described by a physician in the 1860s:

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[93] Ibid., 261; NLA Master's Journal, 26 November 1816, quoted in Cherry, *Mental Health Care in Modern England,* 43. R.W.'s sister was most likely Susan Watson, who was reported to have died on October 24 1816 only a week following her admission to Bethel Hospital: NRO, BH12, Minute of 4 November 1816.
[94] Porter, *Mind-Forg'd Manacles,* 273; Reaume, *Remembrance of Patients Past,* 37.
[95] Houston, *Madness and Society in Eighteenth-Century Scotland,* 216.
[96] NRO, BH78; NRO, BH46; Hamlett and Hoskins, "Comfort in Small Things?," 108.

> for many years she was extremely violent, but for the last few years she has been very quiet and harmless and has shewn no sign of insanity beyond unnatural irritability. […] She has been in the hospital longer than any other patient.[97]

Evidently sixty years of confinement had mollified her somewhat. Other patients changed their behaviour much more quickly in the hospital as they apparently adapted to the alien rhythms of institutional life. In 1814, former baker John Scott, confined a second time for 'general delusion.' was said to have been "formerly […] noisy and violent," but now "vry quick and […] cheerful & happy." Scott's adaptation was not evidently considered sufficient to earn him a discharge, however. He stayed at the hospital, assisting with its work, until his death in 1860.[98]

The most dramatic act of violent resistance in the hospital occurred on March 29, 1813. Jonathan Morley, originally from Suffolk, was likely first admitted to Bethel in 1810.[99] Three years later, Morley was assigned to cut the grass in the inner courtyard of the hospital "as he had been accustomed to do." The circumstances of what happened next are debatable. According to the earliest account, while Morley was cutting the grass with a scythe,

> the Governor [i.e. Master James Bullard] came up to him, and observed, he did not think he was mowing it the right way; this gave [Morley] so much offence, that he immediately struck at him with the sharp end of the scythe, which penetrated into his body, making an extensive wound.[100]

Another early newspaper account stresses Morley's "apparent recovery" of his sanity prior to the incident, likely to explain why Morley was allowed access to such a dangerous tool in the first place. It is significant that both of these accounts do not describe Morley as insane or a 'lunatic.' The first account in particular narrates the attack as a rational (i.e. understandable) act, speculating that it arose from Morley's hurt pride at being criticized by his supposed superior under confinement. Why an "apparently recovered" patient remained in confinement rather than

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[97] NRO, BH46.
[98] Ibid.
[99] *Norfolk Chronicle,* 28 August 1813; Suffolk Record Office, Bury St. Edmunds, FL507/7/8/6.
[100] *Bury and Norwich Post,* 31 March 1813, p. 3.

being discharged is not made clear in the contemporary accounts (but may have had something to do with the labour Morley had provided the hospital).

Bullard languished for almost a month before succumbing to his wounds. At a special board meeting in late April 1813 the hospital governors reported that

> James Bullard the master died on the 24th day of April instant in consequence of a wound on his Body inflicted […] with a Sythe by Jonathan Morley one of the Patients […] a Verdict of Wilful Murder was given against the said Jonathan Morley.[101]

Bullard's death sent shock waves through the surrounding community, prompting a Norwich minister to give a sermon on his killing and the "awfulness of death" to an audience of more than 3000.[102] Notably, similarly to the newspaper accounts, the board's verdict of 'wilful murder' ascribed rationality and lucidity to Morley's act despite his supposed insanity. Morley was taken into custody until his trial. He pled not guilty but refused to go to trial, quoted as saying simply that "he knew nothing about it, and how could he be tried for what he had never acted." If this was an attempt to establish an insanity defense, it apparently worked. A jury found a verdict of insanity and remanded Morley to the Norwich gaol.[103]

From there, in 1816 Morley was moved to the infamous Bethlem Hospital in London, where later in 1823 he became one of the many patients described by the anonymous author of *Sketches of Bedlam.* The (sensationalized)[104] account focused particularly on then-45-year-old Morley's strong physical vigour and cheerful disposition:

> although his intellect be gone past all hope of restoration, his bodily faculties seem to have sustained no deterioration […] He can wrestle, tumble, dance, throw somersets, walk on his hands […] and perform many other feats of the same kind. He sings, and always appears cheerful, happy, exempt from care, sorrow - and reflection.[105]

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[101] NRO, BH12, Minute of 26 April 1813.
[102] *Norfolk Chronicle*, 22 May 1813.
[103] *Bury and Norwich Post*, 25 August 1813, p. 4; *Norfolk Chronicle,* 28 August 1813 p. 2.
[104] As Roy Porter notes, the work was intended more for "mirth rather than insight": Porter, *Mind-Forg'd Manacles*, 240.
[105] *Sketches of Bedlam; or, Characteristic Traits of Insanity* (London: Sherwood, Jones and co., 1823), 63-64.

Years of confinement had apparently done little to temper Morley's mood in the wake of his murderous act. In just one swift motion, he had single-handedly overturned the hierarchy of Bethel Hospital. His subsequent cavalier attitude to his momentous actions ("he knew nothing about it") unknowingly echoed Bethel's other homicidal patient, Thomas Callaby: "he confessed it, but said he did not care any thing about it."[106] Morley and Callaby's apparent total absence of remorse likely unsettled many around them, as they had become the culmination of what early modern societies feared most about 'lunatics'' capabilities for unsanctioned violence. Such extraordinary cases, and the fear they inspired, likely shaped how many perceived and responded to the other apparently mad people in their communities, regardless of whether or not they displayed violent tendencies.[107]

But violence was not the only way to resist the impositions of the hospital. Another way (as discussed in Chapter Two) was by escaping the hospital grounds. Evidently even at the end of our period, the hospital buildings were not entirely secure. On July 1st 1811, the board ordered Edward Simpson be discharged, but he was reported to have "left this Hospital of his own accord a few days previous."[108] Other less visible acts of resistance could also consist of transgressive speech-acts or forms of deliberate inaction,[109] although no evidence survives of such acts at Bethel during this time period.

Besides isolated violent acts and other forms of resistance, it appears that many of Bethel Hospital's patients peaceably complied with the hospital and even acted as servants within it to

[106] *Norfolk Chronicle* 10 August 1805 p. 2.
[107] Rushton, "Lunatics and Idiots," 40-41.
[108] NRO, BH12, Minute of 1 July 1811. The board decided to confirm his discharge anyway.
[109] E.g. Percy, "Writing from the Asylum: Martha Shakespear Lloyd at the Linguistic Limits of Eighteenth-Century Femininity," 112.

advance their situation. The great irony of Jonathan Morley's case is that he had been among these patients, regularly assisting in gardening at the hospital, before his sudden attack on the hospital's master.[110] More typically, though, servant-patients were women, and did not engage in violence. The practice of employing institutional inmates had precedent at workhouses as well as private madhouses.[111] There is notable evidence to support patients viewing servanthood as a form of self-advancement and assertion of autonomy, particularly if they had no other place to go.[112]

At Bethel similar arrangements appear to have been in place from a relatively early date, with some patients acting as servants for extraordinarily long periods of time while regularly receiving clothing. Patient Hannah Thompson was provided clothing from 1805 to 1809. In 1811 it was reported that Thompson died in the hospital and had "been a patient for the space of 53 years during which time she was a trusty useful Servant to this Hospital although a lunatic."[113] Similarly, Mary Jackson was provided various items of clothing from 1803 to 1811. In 1812 she died in the hospital. The Master, James Bullard, paid her funeral expenses "as a mark of respect she having been 22 years a patient in this Hospital and during which period been very serviceable."[114] The pattern of clothing provision suggests that it was one benefit of long-term servanthood.

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[110] *Norfolk Chronicle,* 3 April 1813.
[111] Cherry, *Mental Health Care in Modern England,* 65; Susan Tyler Hitchcock, *Mad Mary Lamb: Lunacy and Murder in Literary London* (New York: W. W. Norton and Co., 2005), 57.
[112] e.g. in Bethlem patient James Tilly Matthews' architectural plans for the new Bethlem Hospital, he envisioned a 'grand kitchen' where patients could work as part of a community: Jay, *The Influencing Machine,* Kindle edition, ch. 7.
[113] NRO, BH2; NRO, BH3; NRO, BH12 Minute of 4 April 1811. Her death was even reported in a local newspaper*: Norfolk Chronicle*, 6 April 1811, p. 3.
[114] NRO, BH12, Minute of 3 January 1803; Minute of 5 June 1804; Minute of 3 June 1805; Minute of 11 August 1806; Minute of 3 April 1809; Minute of 1 June 1812. She remained in the hospital for at least nine more years: NRO, BH1551.

Another benefit could be the reduction or outright cancellation of maintenance payments. Ann Burgess had her payments cancelled in 1810 "in consideration of her usefulness in this Hospital and the work she performs."[115] In very rare cases, patients were even able to transcend their inmate status altogether by these means. In 1755, the board ordered that Ann Paper, "a Lunatick in this House be discharged And that she be employed from this time as a Servant."[116] Hers is a particularly striking example of how one could escape from confinement and the stigma of lunacy through servanthood. Paper's case is very much the exception, though. As discussed, most servant-patients remained confined in the hospital long after they offered their services. Indeed, the hospital board had a strong economic incentive to prevent their discharge in order to retain their labour.[117] Thus for most of Bethel's patients, choosing the path of servanthood often brought mixed blessings: privileges afforded within the institution at the expense of potentially being less likely to leave it.

3.5 Madness' Shadow: Life After Institutionalization

For patients that did manage to survive their time at Bethel Hospital and be discharged, the stigma of being labelled a lunatic often followed them out into their communities. Simply having been restrained in any way was often seen as synonymous with being mad.[118] Sometimes patients' patterns of socially aberrant behaviour landed them back in Bethel following discharge. In 1773, Dapling Day was discharged after his relations "promised to […] not suffer him to go about to the Annoyance of the Inhabitants as he has frequently done." But only a year and a half

[115] NRO, BH12, Minute of 1 January 1810; NRO, BH1178/1.
[116] BH10, Minute of 7 April 1755.
[117] Cherry, *Mental Health Care in Modern England,* 16.
[118] Houston, *Madness and Society in Eighteenth-Century Scotland,* 182.

later, he was again discharged from Bethel.[119] Others met even more unhappy ends. In 1807, one Sarah Harper was found drowned in the River Wensum in Norwich. A coroner's inquest failed to reach a verdict, but the jurors asserted that 50-year-old Harper "hath been frequently deranged in her Intellects & in consequence thereof ^was once confined in Bethel."[120]

As Harper's case hints, often former patients of Bethel were known as such to their communities and lived with considerable lasting stigma.[121] Amelia Opie's autobiography of her early childhood in 1770s Norwich provides further insight into the lives of these individuals:

> two poor women […] lived near us, and were both deranged though in different degree. The one was called Cousin Betty, a common name for female lunatics; the other, who had been dismissed from bedlam [i.e. Bethel] as incurable, called herself "Old Happiness," and went by that name. These poor women […] passed by our door every day; […] when I saw them coming (followed usually by hooting boys) I used to run away to hide myself.[122]

Opie's account reveals many aspects of the stigma faced by individuals deemed mad in Norwich. In the case of these former patients of Bethel, their histories of institutionalization were public knowledge, and they lived in poverty, were given stereotyped nicknames ('Cousin Betty'), feared by children and even routinely harassed in the streets. But significantly, Opie's account also suggests that former patients (particularly women) could find comfort in each other's company.

Perhaps unsurprisingly, lasting social ties could be formed between patients in Bethel Hospital's wards.[123] Such bonds may most prominently be seen in the case of Ann Smith and Mary Green. Ann Smith, originally from Metton in Norfolk, was held at Bethel Hospital from

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[119] NRO, BH11, Minute of 4 January 1773; Minute of 4 July 1774.
[120] NRO, NCR 6a/16/32.
[121] As Roy Porter has usefully explained, "the act of stigmatizing defines difference, dubs it inferiority, and blames those who are […] different for their otherness." Porter, *Mind-Forg'd Manacles*, 42-43.
[122] Opie, *Memorials of the Life of Amelia Opie,* 13-14.
[123] Erin Spinney found similar lasting ties in her study of 18th-century naval hospitals: Erin Spinney, "Naval and Military Nursing in the British Empire c. 1763-1830." PhD Diss. (University of Saskatchewan, 2018), 168.

July to September 1812 at the age of 28.[124] Mary Green's timeline at Bethel Hospital is slightly less clear; originally from Norwich, she was first admitted at the age of 34 in 1811 and discharged the same year as recovered. However, she had at least two subsequent stays at the hospital of indeterminate length over the next three years.[125] They next show up in the historical record together in the context of a personal tragedy.

A coroner's inquest was taken on the body of an infant named William Smith in Norwich on July 6, 1816. It concluded that the child had been accidentally poisoned by his mother, Ann Smith, at 'her lodgings in the dwelling house of Mary Green.' Based primarily on the testimonies of a druggist and Mary Green, the inquest found that Ann Smith and her three children had all been afflicted with "the Itch" (i.e. scabies). Smith asked a local druggist for a remedy, and he provided her with (poisonous) Hellebore, and "some powder'd Black Brimstone for her to make into an [ointment]." In addition to the ointment, the druggist also advised her to ingest some of the Brimstone. This is where trouble arose. Mistaking the Hellebore for the Brimstone, Smith swallowed a portion of it and had her children do the same. All four of them subsequently got sick, and William died.[126]

There are enticing as well as tragic elements to this account. Black Hellebore was notably used as a purgative treatment for madness since antiquity,[127] and so it is tragically ironic that medical authorities' prescription of it ended up doing so much harm to an individual that had likely already been treated with similar substances at Bethel. But the most significant aspect of

[124] NRO, BH77; BH12, Minute of 7 September 1812.
[125] NRO, BH77; NRO, BH12, Minute of 6 April 1812; Minute of 4 July 1814.
[126] NRO, NCR 6a/22/11.
[127] Black Hellebore was frequently used as a purgative in the 18th century as well: Robinson, *A New System of the Spleen, Vapours, and Hypochondriack Melancholy,* 395; Munro, *Remarks on Dr. Battie's Treatise on Madness,* 55.

this case is the lasting social bond it reveals between two former patients of Bethel Hospital. In her testimony, Mary Green feelingly attested to Ann's character, testifying that Smith and her young family "have lodged in her house for some time, that she always behaved with great care and tenderness towards her children, and in all respects as a good & affectionate Mother."[128]

Living together likely had a significant economic benefit for two unmarried women in this time, but Mary Green's testimony also reveals a deeper social bond of friendship potentially formed in the women's ward of Bethel. Overall, these final cases illustrate an important point: that life did not necessarily end for all people confined in Bethel Hospital. In general, the experiences of confinement, treatment and even abuses in lunatic hospitals could be survived and transcended, even in spite of the stigma that followed. It is also enlightening to see through the case of Ann Smith and Mary Green that the shared experiences of confinement could have the unintended effect of bringing together people who lived under the stigmatization contained in labels of madness, and also lived together in the shadow of the conditions they had been subjected to. It is a testament to their resilience.

[128] NRO, NCR 6a/22/11.

Conclusion

> *A young woman, who calls herself Lady Anne Stewart, was last week committed to the Wymondham Bridewell. She is about 24 years of age, and appears to be insane; she is short and stout made, has a ruddy full face, pitted with the small-pox, and has a girl with her, about five years old, whom she calls her daughter […] says that she has been confined in three different Bethels, but always made her escape […]*
>
> —*Bury and Norwich Post*, 8 November 1786[1]

> *Let Hur rejoice with the Water-wag-tail, who is a neighbour, and loves to be looked at. For they pass by me in their tour, and the good Samaritan is not yet come.*
>
> — Christopher Smart, *Jubilate Agno*[2]

More than a century had passed since the 1713 founding of Bethel Hospital in Norwich. It had continually expanded over this period as it met ever-rising demands for institutional provision for the insane in the communities surrounding it. Over these decades, Bethel served as a center where public perceptions of madness translated into the confinement of individuals who were either feared to pose a danger to others or themselves, or alternately became too overwhelmed to function in everyday life. As we have seen, the perceptions of madness within the many communities of Norwich, Norfolk, Suffolk, and beyond were shaped by public discourses of medicine, literature, and religion. Collectively formulated and regulated norms of social behaviour determined the kinds of non-conforming behaviour that would be deemed evidence of lunacy by an individual's wider community. Norms also differed depending on one's gender and socioeconomic status. Hence, as we have seen, there were significant

[1] *Bury and Norwich Post*, 8 November 1786.
[2] Quoted in Richard Stern, "Smart's Authority and the Eighteenth-Century Mad-Business," in *Performance, Madness and Psychiatry: Isolated Acts*, eds. Anna Harpin and Juliet Foster (New York: Palgrave Macmillan, 2014), 32.

interconnections between madness, gender, poverty, and criminality in 18th-century Norfolk. Individuals confined in Bethel Hospital for such actions as wandering from place to place, making noise, using 'improper language,' being unable to give an account of themselves, or not being part of a household had often been targeted by legal or parish authorities for similar behaviour. Such actions drew attention for controverting contemporary social standards of sensibility or morality.

But Bethel was also a place where these individuals were able to carve out for themselves some means to endure, resist or comply with the impositions of the institution, and thereby express a limited degree of autonomy. As we have seen, individuals deemed mad asserted agency in different ways. Combining a patient-centered approach with discourse analysis and considerations of architecture has enabled a richer and more multi-faceted appreciation of how individuals experienced confinement in Bethel Hospital over time and responded to the physical and social enforcement of its boundaries. Attending to the local geographical context has additionally helped illuminate the function of the hospital to its surrounding communities.

It is my hope that this thesis sheds light onto long-neglected aspects of the hospital's history, and effectively situates its significance within both a local and national context. The widespread prevalence and expansion of mechanical restraints and chains at Bethel Hospital throughout the period, for instance, is striking yet unsurprising in the context of practices at similar institutions in the long 18th century. Such practices reflected the hospital's administrators' increasingly sophisticated exercise of control over patients' mobilities within the hospital over time. These developments enabled hospital staff to regulate the confinement of an ever-growing patient population as the hospital continually expanded its facilities. Attending to these inner workings of the second public institution for the mad in England enriches our

understanding of how, when and why such institutions introduced different technologies and tactics of restraint at the level of everyday practice.

The chains only fell off at Bethel over the decades to come, as the institution slowly integrated the precepts of moral treatment and realized its capability for general non-restraint in the 19th century. By the late 1850s, not a single one of Bethel's almost 80 patients were in chains, a situation that strikingly illustrates the ultimate superfluity of the hospital's storage of nearly 200 mechanical restraints in the early 19th century.[3] While the various factors precipitating this later shift are beyond the scope of this thesis, the important thing to note here is the continuity of the conventional methods of restraint-oriented management and 'heroic' humoural medical treatments at Bethel from 1713 to 1815, in spite of wider developments in public discourse. The case of Bethel illustrates that developments such as those of the Tukes were slow to become standard practice among other established institutions.[4] Glimmers of the possibilities of therapeutic change are apparent in Bethel's records, but members of the hospital's administration tended to collectively override individual innovations (e.g. the short-lived introduction of pigeons and poultry in the hospital's courtyards discussed in Chapter One).

Bethel Hospital's patients indeed had a widely differing range of experiences of the hospital depending on a variety of personal factors including gender, socioeconomic status, the extent of their social networks, and whether they opted to resist hospital authorities or comply with the institution. In general female, poor, and socially isolated patients had fewer life options available to them in certain respects. Such factors motivated institutionalization to a greater

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[3] *Copy of the Fifteenth Report of the Commissioners in Lunacy to the Lord Chancellor* (House of Commons Papers 314, 1861), 27. The report describes an inspection of the hospital conducted in 1857; see Chapter Two.

[4] As Leonard Smith has concluded, the innovations of the Tukes and Pinel did not begin to exert considerable influences upon practices in England until at least the establishment of the new County Asylums in the 1810s: Smith, *'Cure, Comfort, and Safe Custody,'* 212-213.

degree for these individuals deemed mad that had little other venues of labour, care, or custody available to them. Thus women and poorer individuals made up a significant proportion of the patient population. These combined factors also informed the options available to individuals once they found themselves confined in Bethel Hospital. For instance, poorer female (and some male) patients could garner the trust of hospital staff in order to gain privileges and material benefits by offering their labour to the hospital. More well-off patients, though, had less incentive to do so. Another common experience of poorer and vagrant inmates was that of trans-institutionalization, as they were shifted between different centers of confinement over time. This meant that for such individuals, discharge from Bethel Hospital did not always equate to their freedom. Thus a select few patients chose to make the hospital their home by acting as long-term servants, with some (namely Ann Paper) even managing to transcend their patient status altogether through these means.

Another important conclusion to draw from this study relates to the issue of violence. Contrary to popular perceptions and representations, as well as the assumptions of some scholars writing about institutions,[5] individuals deemed mad that acted violently likely made up a relatively small proportion of Bethel Hospital's population. We have seen from the evidence of recorded treatments, largely consisting of substances to treat nervous conditions, that cases classified as mania or phrensy (the supposedly more violent forms of madness) likely made up a relatively small proportion of the patients treated at Bethel. We have additionally seen from qualitative sources that melancholic and suicidal individuals and the few but notable servant-patients indeed made up a significant part of hospital life. Accounts relating isolated incidents of extraordinary violence by three of Bethel's male patients in particular (Jonathan Morley, Henry

[5] Approaches assuming the stereotypical violence or potential for violence of mental patients are criticized by e.g. Reaume: Reaume, *Remembrance of Patients Past,* 75, 253.

Case and Thomas Callaby) tended to overshadow the experiences of the melancholic, quiet and subdued, who are only revealed by rare outsider sources such as Amelia Opie's memoirs. The discovery of nine successful patient suicides over the same period suggests that in general, Bethel's patients were more likely to harm themselves than others. As shown, despite common cultural connotations of madness with violence or its potential, individuals could be deemed mad on many other bases, including incomprehensible speech-acts, wandering behaviour, and solitary laughter. As Roy Porter put it, folk wisdom contended that "madness is as madness looks."[6] Its incommunicative, incomprehensible nature often caused people applying the label to fear the worst individuals could be capable of, whether justified or not. Such judgements (and the confinements that resulted from them) reveal more about the common fears of contemporary communities than actual propensities for violence on the part of persons deemed mad.

Once confined in Bethel Hospital, inmates certainly endured many hardships. They were subjected to nullifications of their identities, physically weakened by depletive treatments, experienced restrictions on their mobility, exposure to public view, and the shame associated with being restrained, all of which likely made it difficult to adjust to hospital life. Besides being subject to the authority and in some cases 'undue correction'[7] of hospital staff, patients also experienced material conditions of chronic overcrowding, occasional incursions of rats and disease, and potential harassment or even violence from other inmates. It is therefore unsurprising that a number of patients staunchly resisted their confinement, whether through escapes or occasionally through more violent means.

Despite the many difficult and negative aspects of their experiences at Bethel Hospital, though, it is significant that many patients were able to find or create small daily comforts that

[6] Porter, *Mind-Forg'd Manacles,* 42-43.
[7] See the case of Master Robert Waller discussed in Chapter Two.

afforded them a degree of stability and community in confinement. In spite of administrators' sporadic efforts to control visitors' access to patients, we find from Amelia Opie's account that inmates were able to regularly engage with and receive money or gifts from members of the public outside Bethel's walls, as well as the many formal visitors that explored its interior at will (a mixed blessing to be sure). More significantly, patients could also find comfort in each other in their shared institutional experience, and we have seen from the cases of Mary Green, Ann Smith and Old Happiness that indeed individuals could form lasting social bonds within Bethel Hospital's wards as well as on the outside. Such ties likely helped sustain patients as they navigated both the confined, alien rhythms of institutional life, and the widespread stigma and harassment that surrounded them when (or more accurately, if) they returned to their communities.

The Many Stories of Bethel Hospital

Mary Chapman's vision carried on far past the period under discussion, and Bethel Hospital underwent further expansions and developments well into the 20th century, becoming an increasingly openly custodial institution and then finally an outpatient clinic before its eventual closure in the 1990s.[8] It left in its wake the formerly long-forgotten stories of the many people that had been confined there in the 18th century. There is a somewhat arbitrary element to the periodization of any study. This thesis has examined the workings of Bethel Hospital and the experiences of its patients from its founding in 1713 to roughly 1815, when the combined recent opening of the Norfolk Lunatic Asylum, the parliamentary uncovering of widespread abuses at Bethlem Hospital in London, and the growing influence of moral treatment all came to significantly change the context and nature of institutional provision at Bethel. But the stories of

[8] Wood, Purcell et. al, *Bethel Hospital, Norwich Conservation Management Plan* no. 3 (September 2016), 9.

many of the patients chronicled here continued far past this latter date. Patients such as Elizabeth King and Hannah Sharpe, who were both in and out of Bethel for over 60 years before dying within it in the 1860s (their brains were dissected and described by a hospital physician after their deaths, a final indignity),[9] likely witnessed radical changes in the nature of the institution and the forms of treatment carried out within it. The specific impacts of such changes on these patients' daily lives in the 19th century remain unexplored and could prove a valuable area of interest for a future study.

The story of Bethel Hospital's first hundred years relates to the birth of institutional forms of care for people deemed mad. The complex, multifaceted history of the hospital reflects the many difficulties and mixed legacies of such institutions. The stories of its patients, though, offer a richer insight into the role of the hospital in their lives, and to the place Bethel Hospital held within the communities surrounding it. It demonstrates the limited forms of agency that these individuals were able to assert over their own lives in conditions of confinement. Most importantly, these stories (the plural is important to stress) underline the need to recognize the individuals held in the first public institutions for the mad not as faceless, stereotyped objects of fear or pity, but rather people with varied origins, personalities, and life stressors, who made choices and acted based on a multiplicity of factors. A patient of Bethel Hospital could be male or female (though more likely female), poor or well-off (though more likely poor), melancholic or outwardly confrontational, resistant or compliant, violent, self-harming or neither. But they all lived under the stigma their communities placed upon them. That at least some of Bethel Hospital's patients were able to connect with each other and endure such conditions speaks to

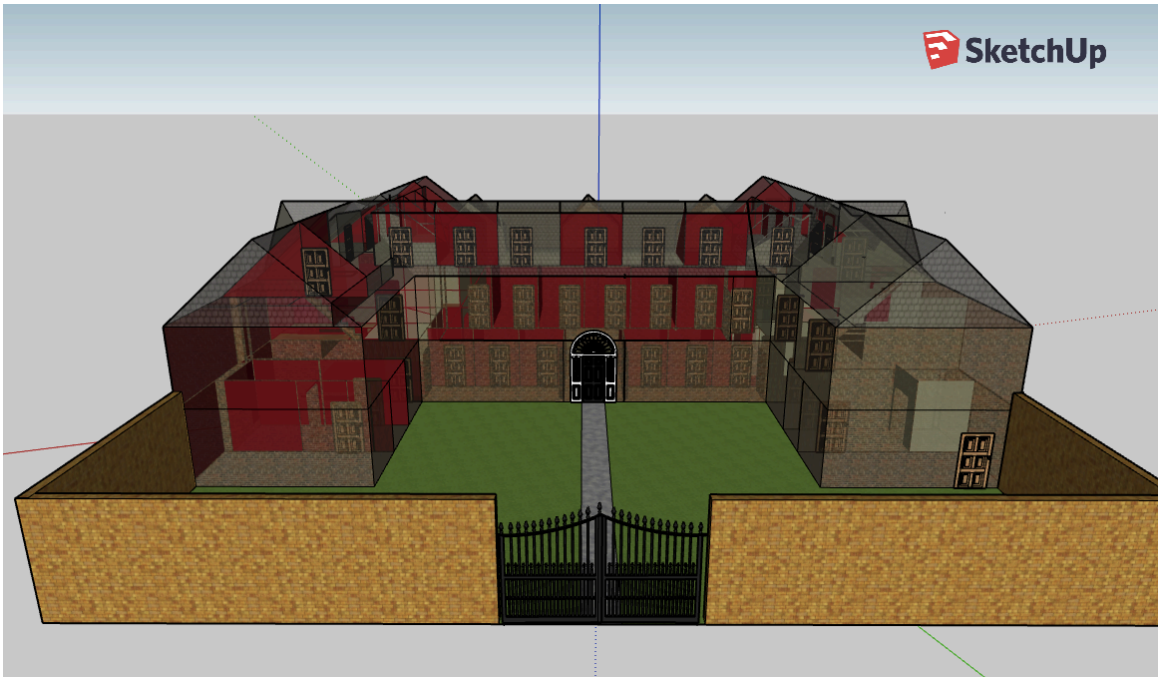
[9] NRO, BH46.

their ability to transcend the burdens and limitations placed on them by both personal circumstances and their communities at large.

Appendix A: Interpretive 3D Models of Bethel Hospital 1727-1766

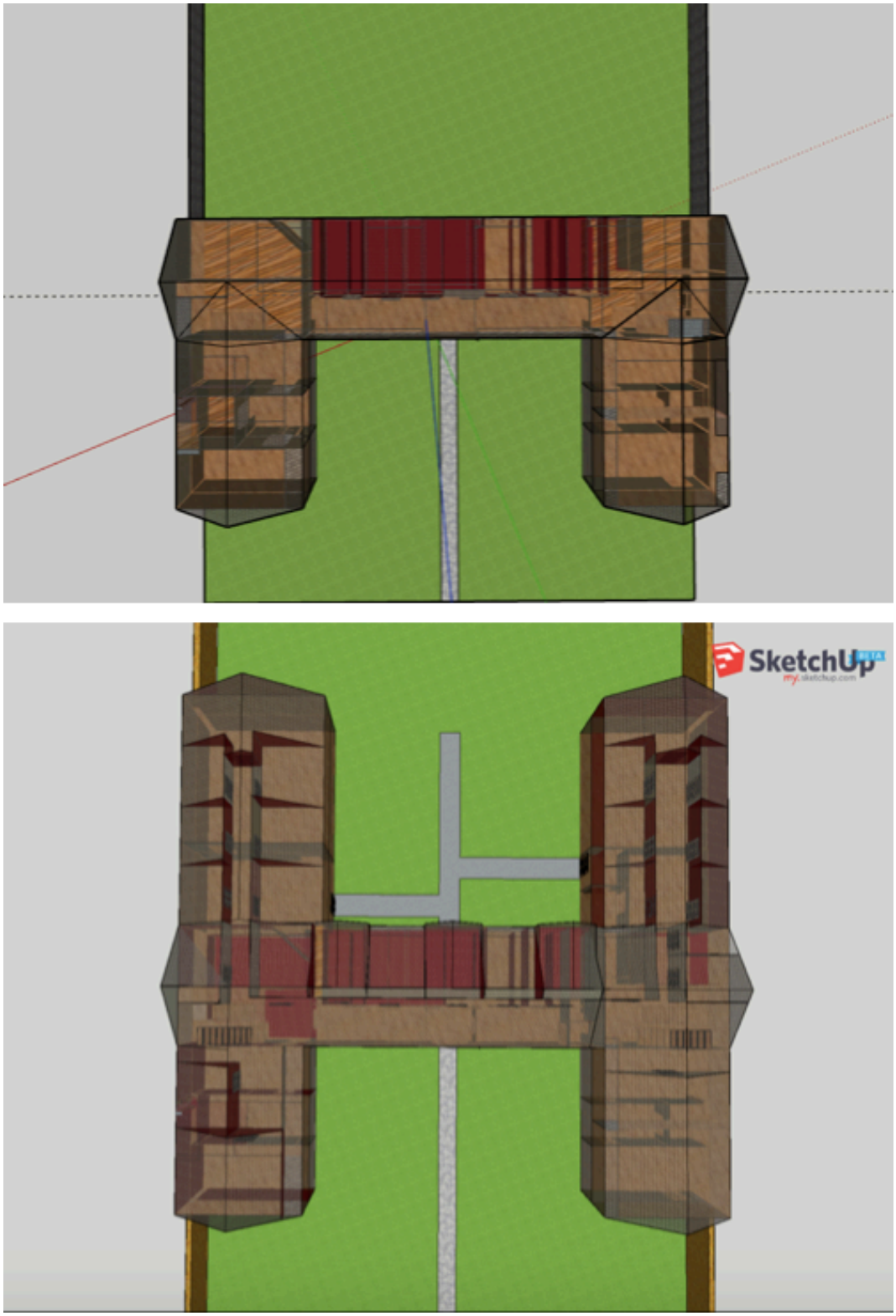
A.1 Front Views (Patient cells/likely habitation tinted red)

1727

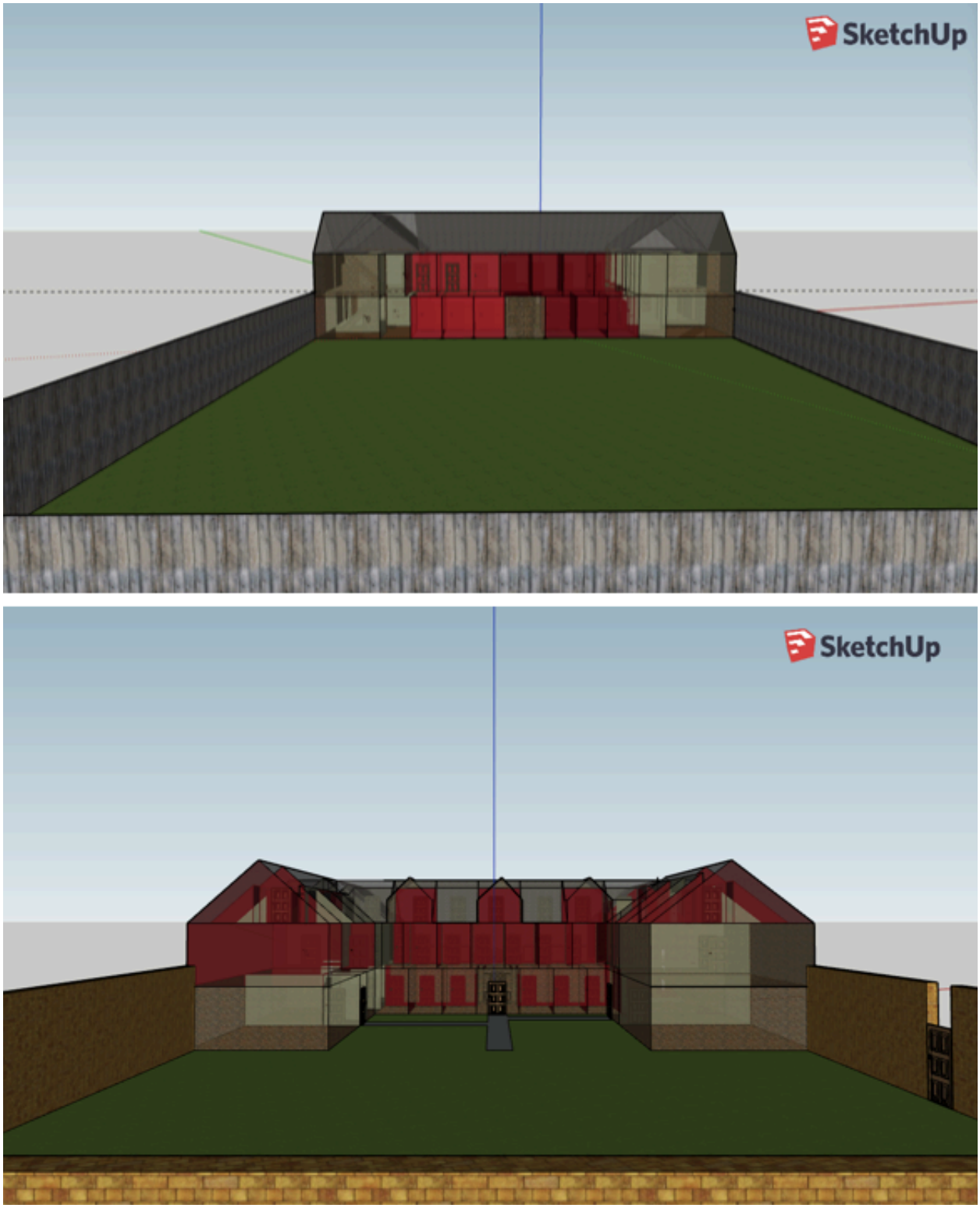


1766

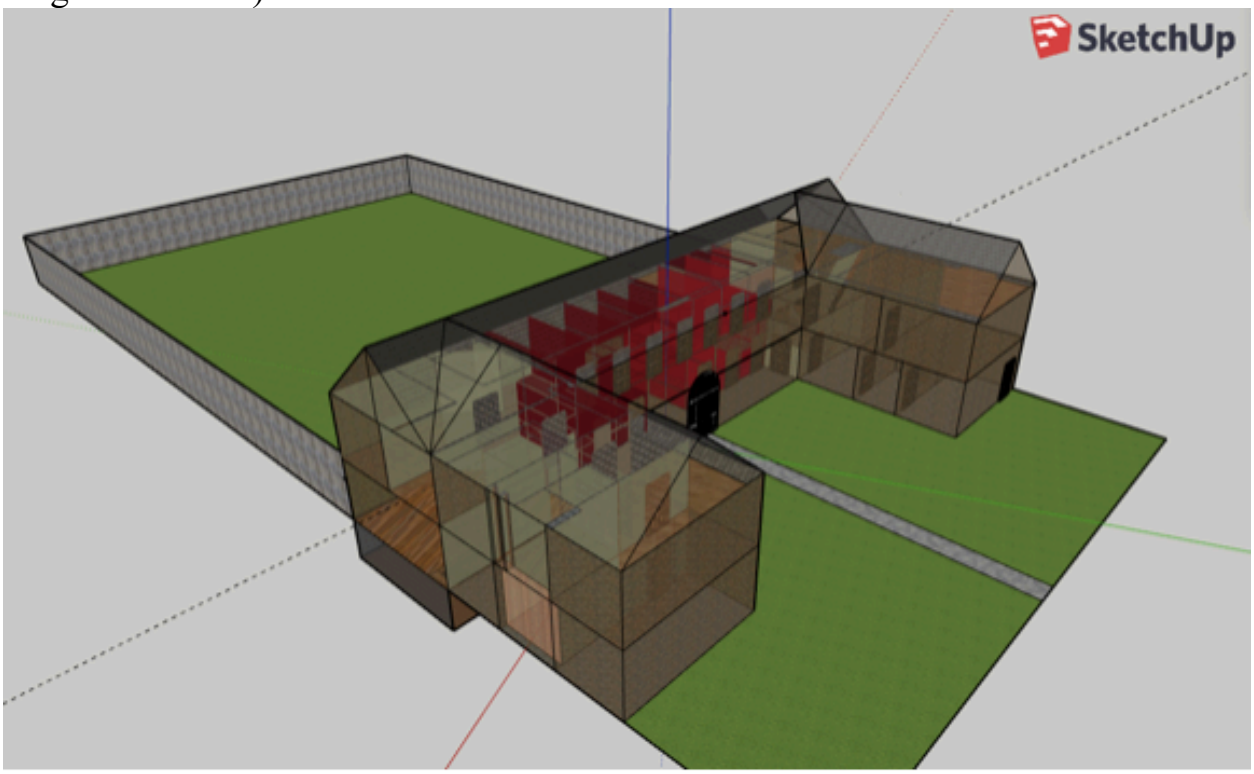
A.2 Overhead Views - Top c. 1727, bottom c. 1766

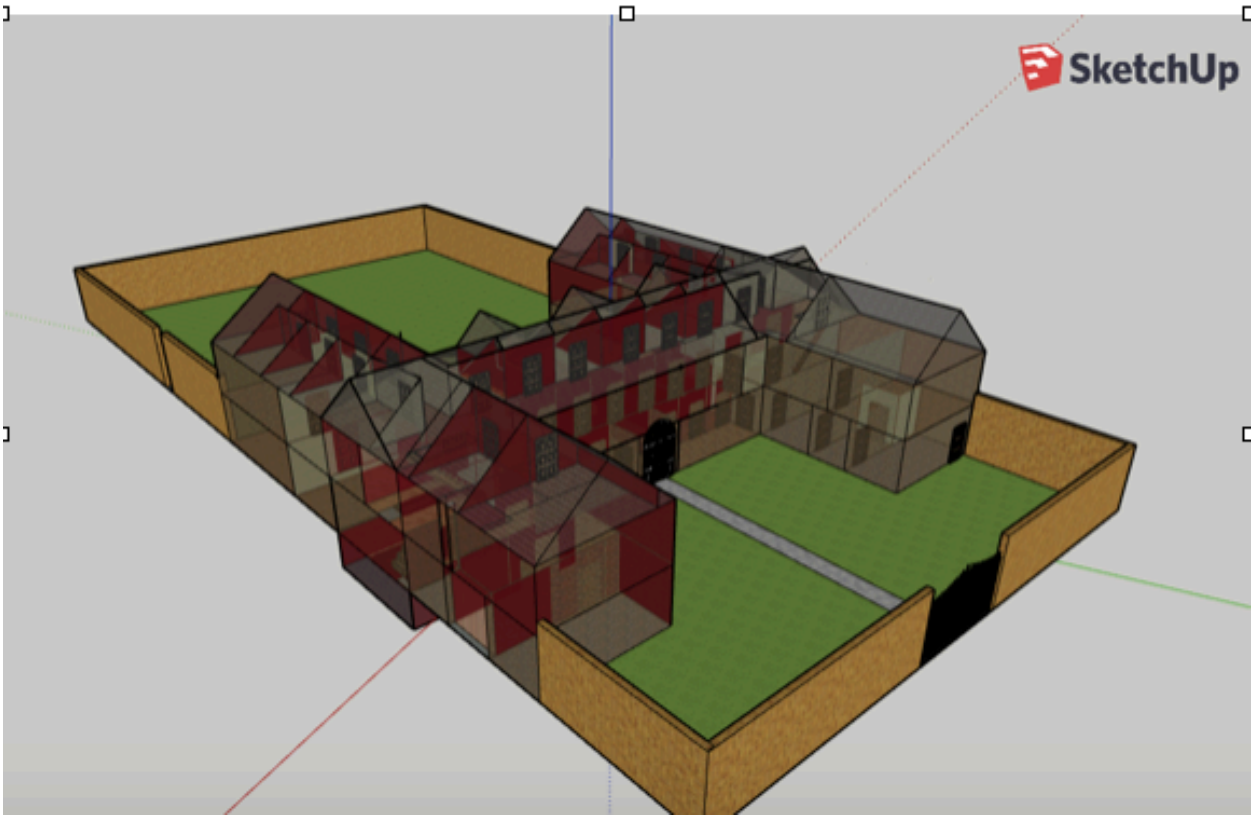


A.3 Views from South Side - Top c. 1727, bottom c. 1766

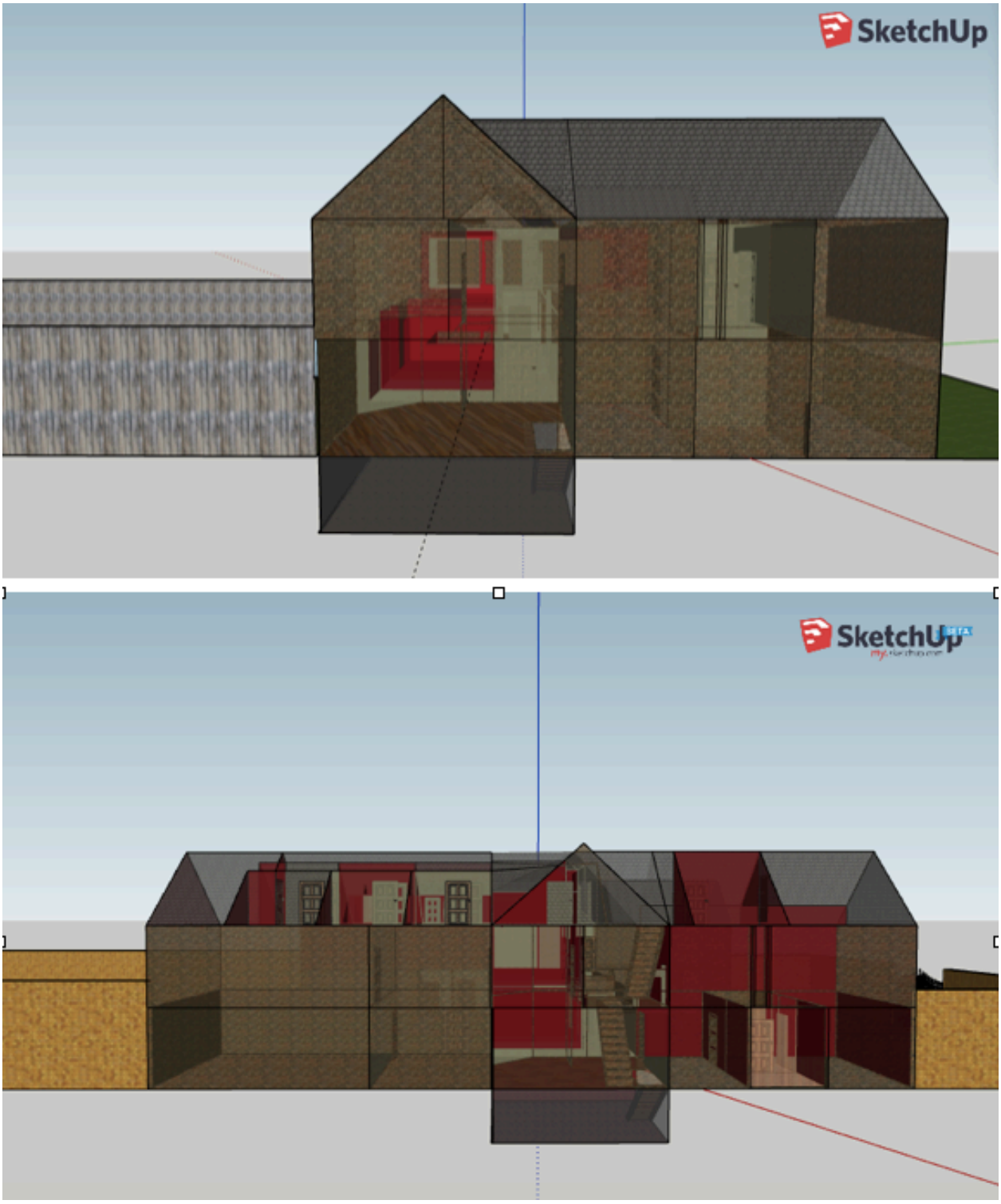


A.4 Isometric, from North-East (green line indicates latitudinal axis, red longitudinal axis)

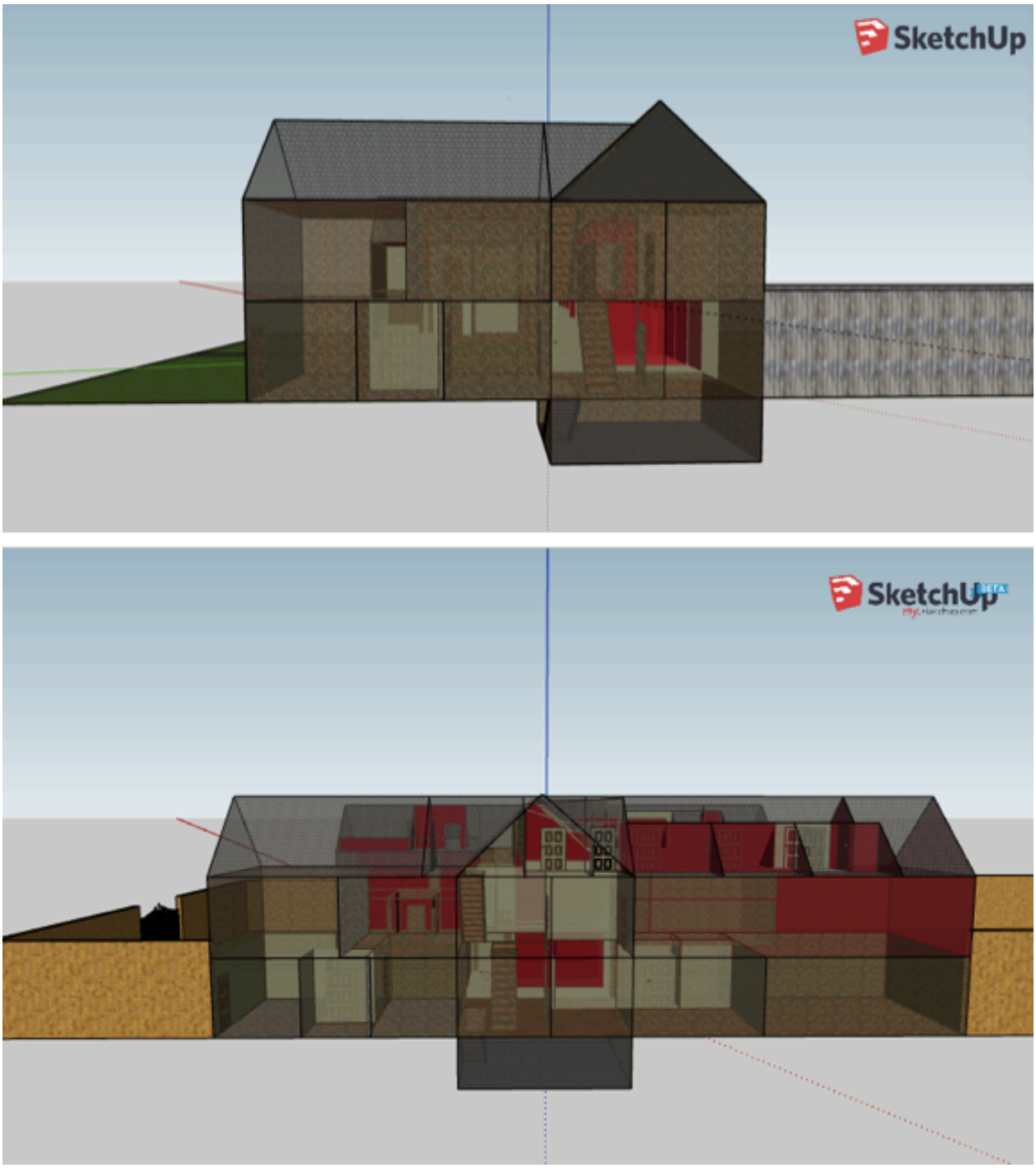




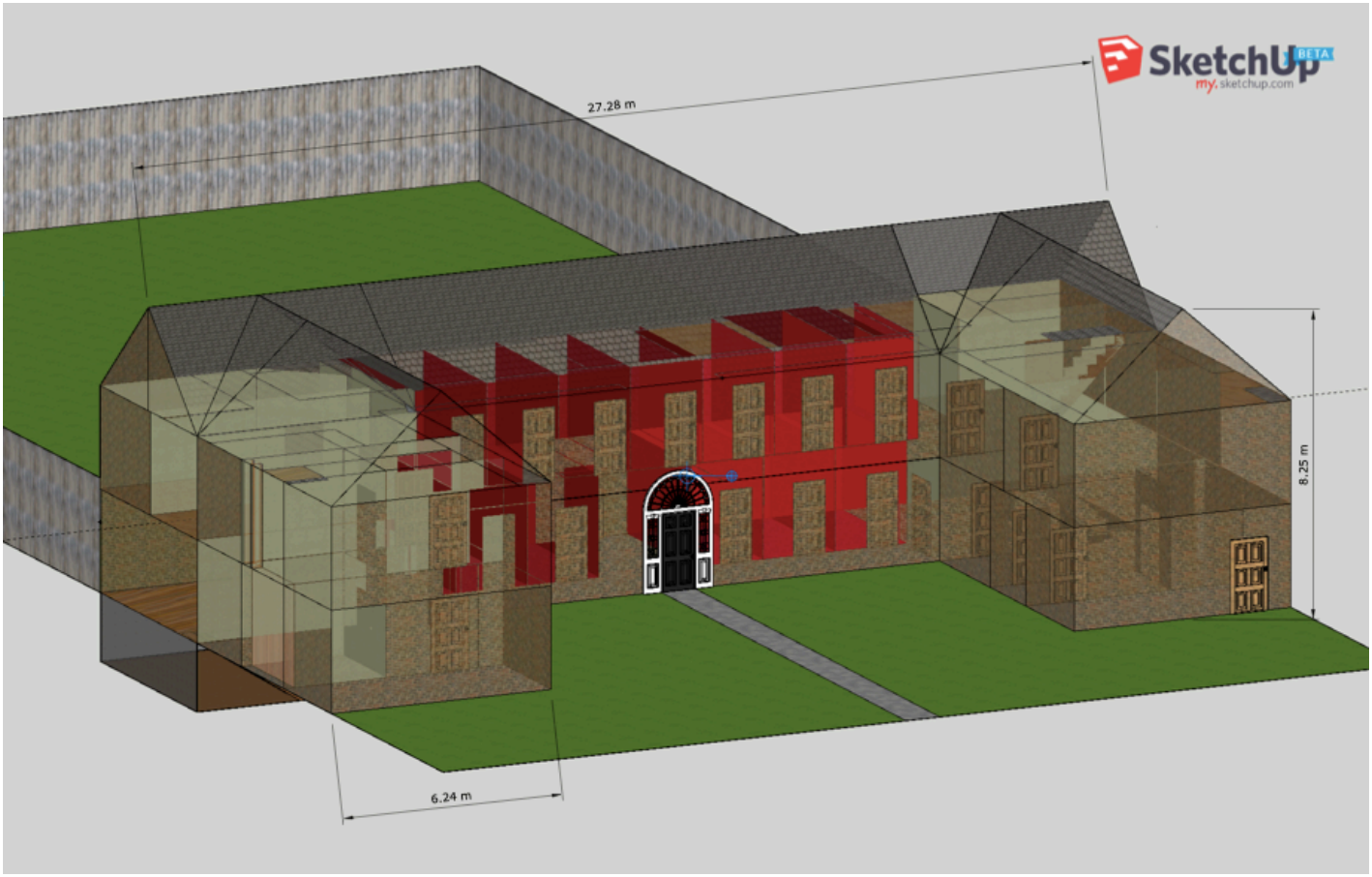
A.5 Side View (West Wing) - Top c. 1727, bottom c. 1766



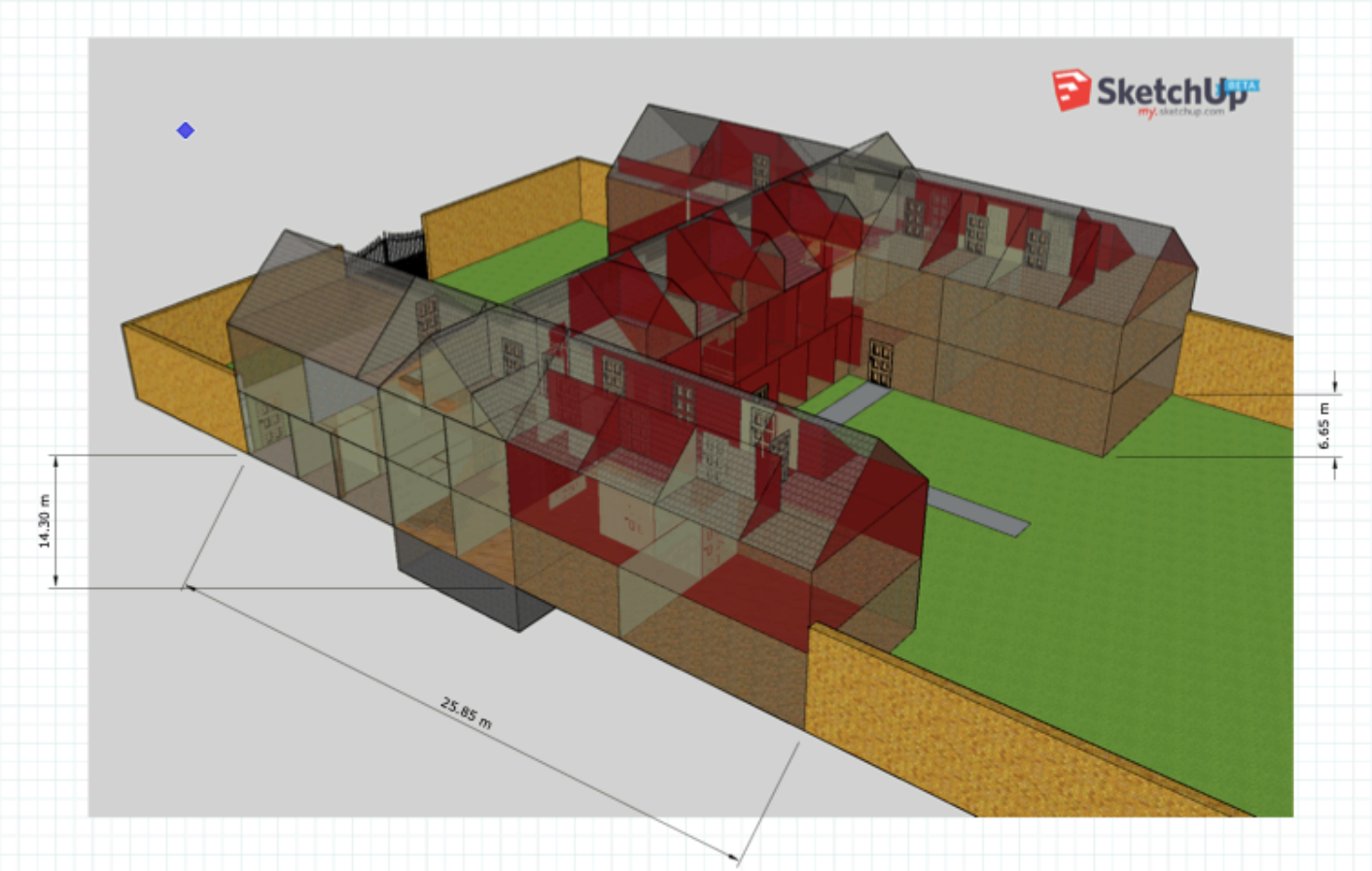
A.6 Side View (East Wing) - Top c. 1727, bottom c. 1766



A.7 Illustrations of Interpretive Models' Approximated Dimensions[1]

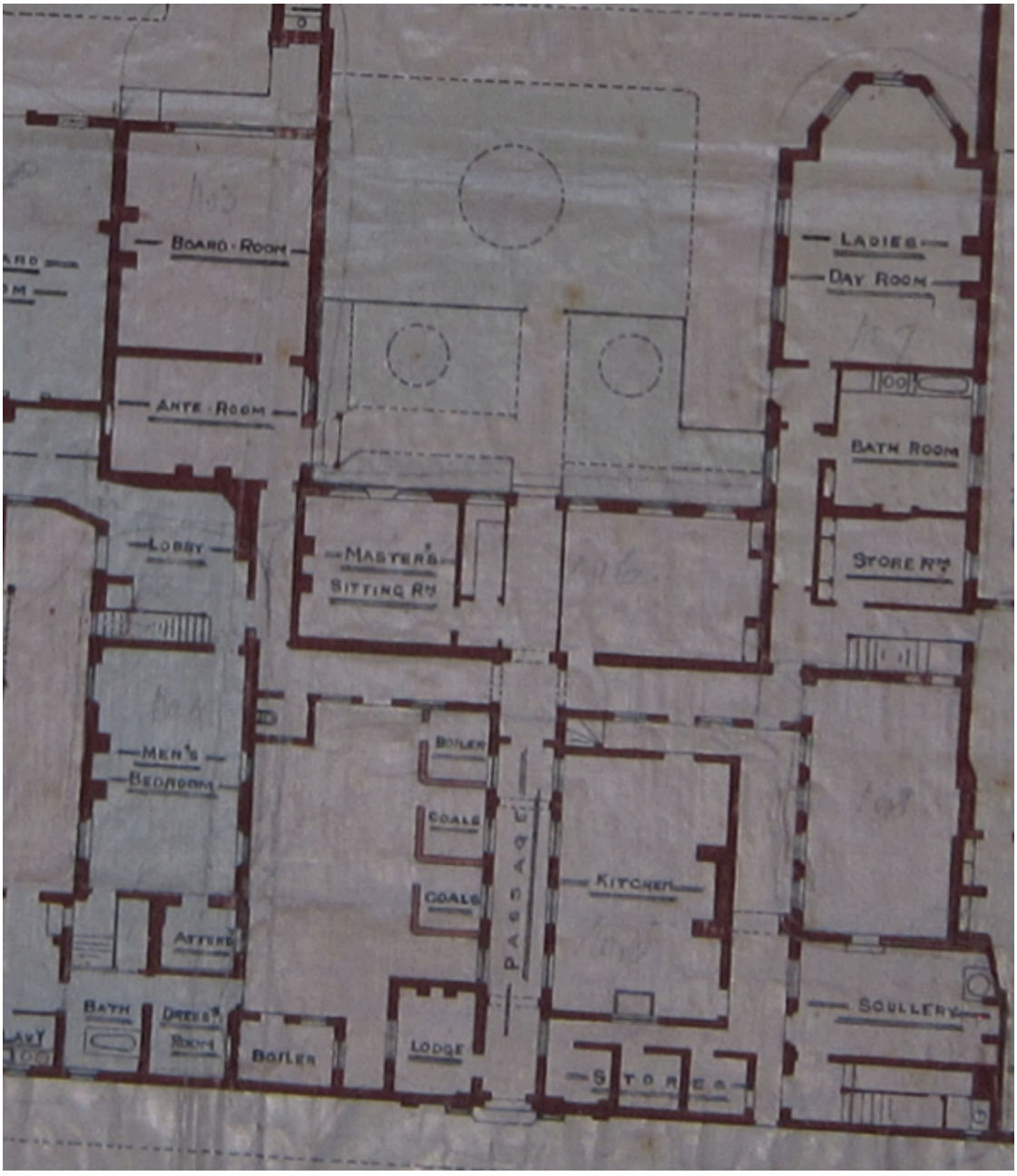


[1] These are provided solely for the purpose of methodological transparency - no firm figures could be reached concerning many of these dimensions in the textual sources, and so interpretative approximations were made on the basis of very limited surviving textual and visual evidence and are in no way definitive or to be taken as indicative.

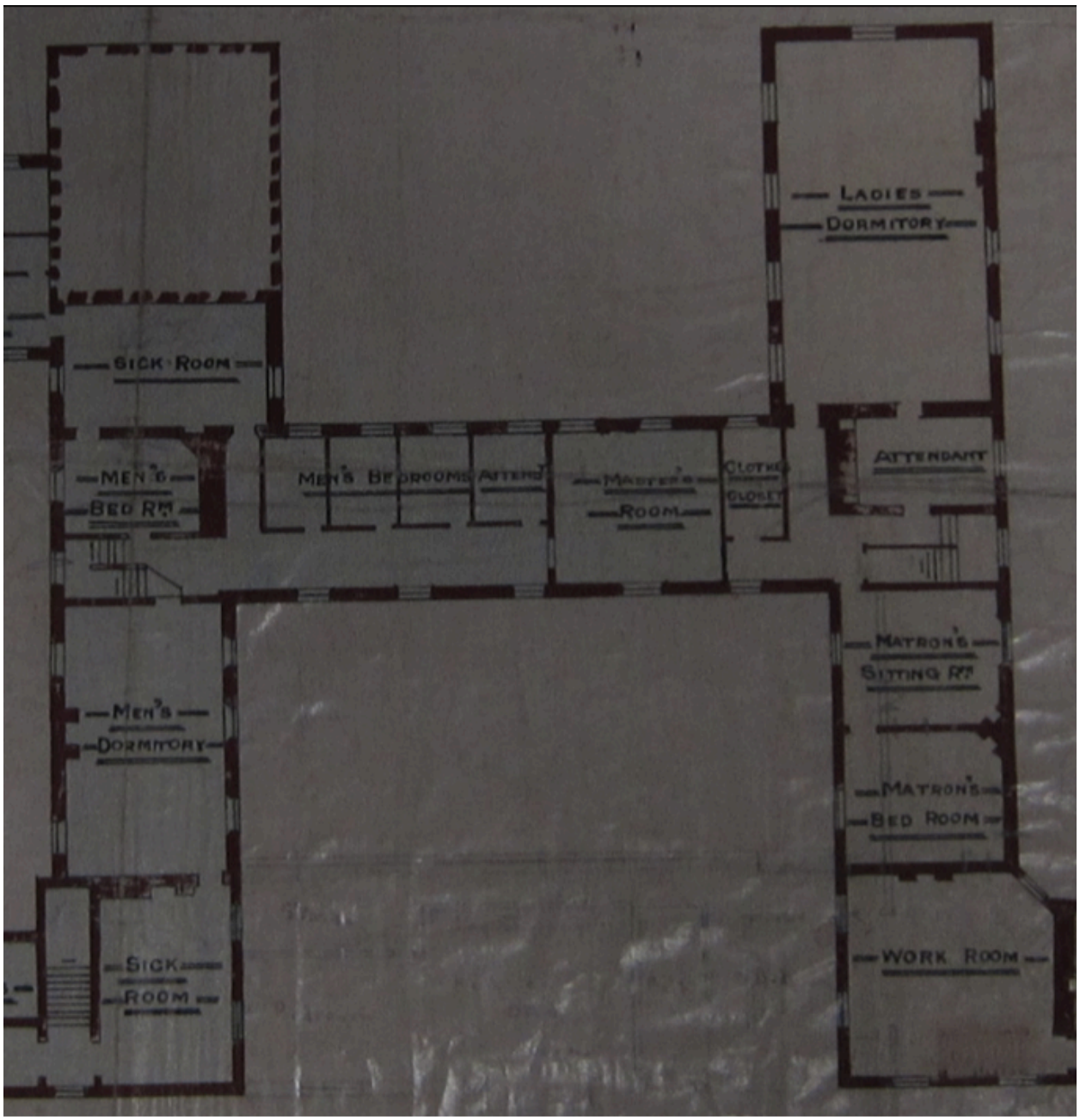

SketchUp
14.30 m
25.85 m
6.65 m

Appendix B: Contemporary Maps and Depictions of Bethel Hospital

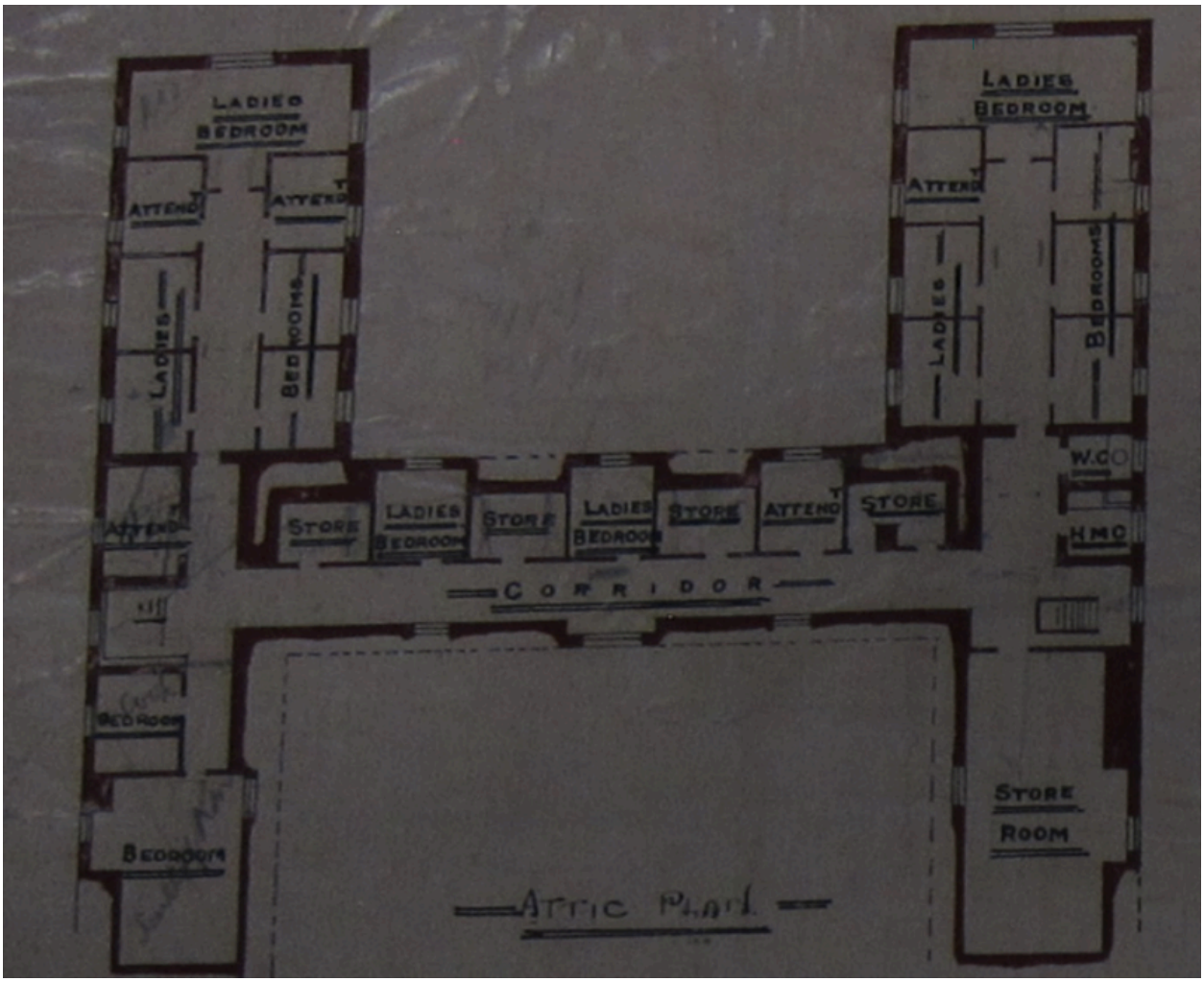
B.1 Detail of NRO, BR 35/2/94/3/1-21 – Ground Floor Plan of Bethel Hospital c. 1893 (showing only the parameters of 18th-century building, but contains many later additions and repartitions – outlined by Rowell et. al)



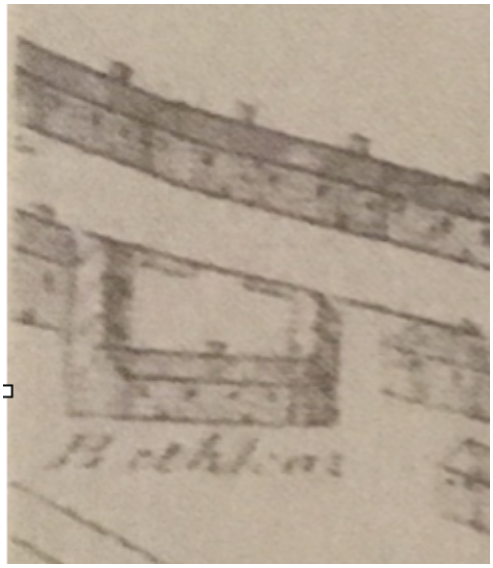
B.2 Detail of NRO, BR 35/2/94/3/1-21 – First Floor Plan of Bethel Hospital c. 1893 (18th-century parameters only; sick room and work room at bottom are later additions; Master's room was originally occupied by additional cells in central block as reflected by 3D model)



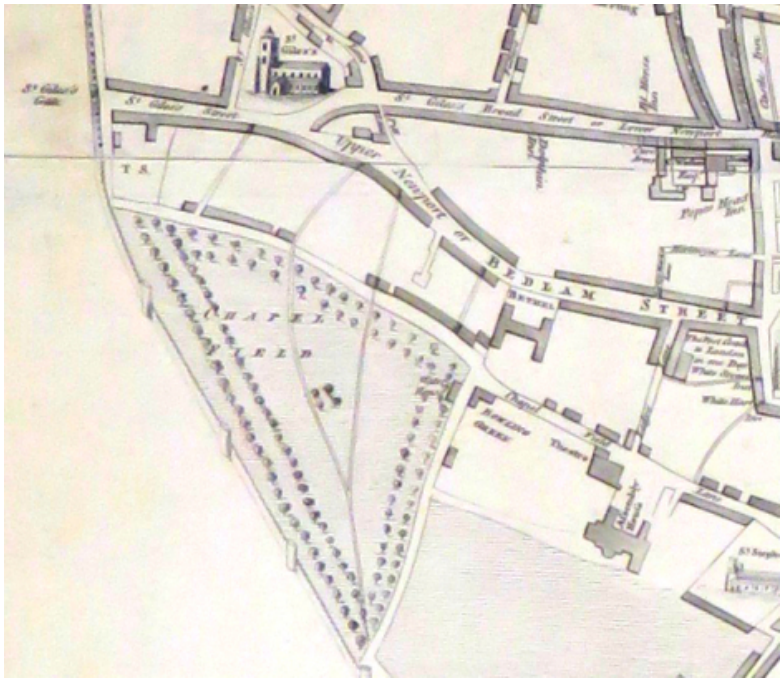
B.3 Detail of NRO, BR 35/2/94/3/1-21 – Second Floor/Attic Floor Plan of Bethel Hospital c. 1893 (18th-century parameters; no apparent major changes in partitions since 1756 expansion according to Rowell et. al)



B.4 Detail of 1727 Corbridge Map of Norwich – Bethel Hospital ('Bethlem')[2]



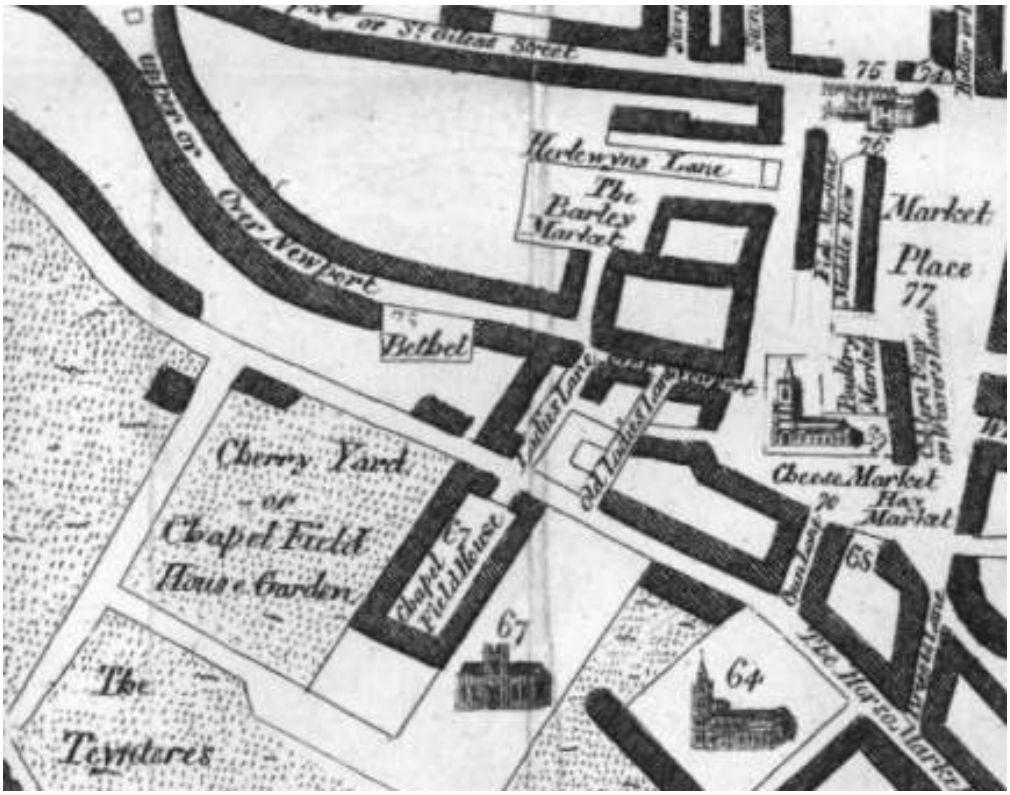
B.5 Detail of Samuel King's map of Norwich c. 1766 - Bethel and Chapelfield Gardens[3]



[2] In Barringer, "The Changing Face of Norwich," 14.
[3] Samuel King, "The City and County of Norwich" (1766), via https://colonelunthanksnorwichdotcom.files.wordpress.com/2018/08/samuel-kingsmapinset.jpg?w=468&h=406. Accessed August 20, 2019.

B.6 1789 Hochstetter Map of Norwich – 'Bethel'[4]

B.7 Detail of 1741 Blomefield Map of Norwich – Bethel and Local Geography, Landmarks[5]



[4] Accessed from http://www.georgeplunkett.co.uk/Website/Maps/1789%20Hochstetter.jpg

[5] Francis Blomefield, "Plan of the City of Norwich." *George Plunkett's Photographs:* http://www.georgeplunkett.co.uk/Website/Maps/1741%20Blomefield.jpg

B.8 Detail of NRO, BR 35/2/94/3/1-21 – Partial Illustration of Bethel Hospital From South (facing back yard) c. ~1893

B.9 Official Seal of Bethel Hospital - date unknown[6]

[6] Bateman and Rye, *The History of the Bethel Hospital at Norwich,* Plate 1.

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BH1170/9.
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BH1178/1.
BH1178/3.
BH1181/3/3.
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BH1532.
BH1537.
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BH1552.
BH1554.
BOL 2/113/15.
BOL 2/113/16.
BOL 2/113/17.
BR 35/2/94/3/1-21.
CASE 15c/1/25.
NCC Lawrence 216.
NCR 6a/5/20.
NCR 6a/5/25.
NCR 6a/5/42.
NCR 6a/7/83.
NCR 6a/7/148.
NCR 6a/8/41.
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NCR 6a/8/85.
NCR 6a/13/49.
NCR 6a/14/43.
NCR 6a/15/25.

NCR 6a/16/12.
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NCR 6a/22/11.
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